September 27, 2019

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

RE: CMS-1715-P, Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Ms. Verma:

On behalf of our 26 acute care hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) physician fee schedule (PFS) proposed rule for calendar year (CY) 2020.

The NHHA fully supports some of the items proposed in this rule. We support CMS’ proposal to improve quality, promote regulatory relief, ensure access to care, and support public health efforts. We strongly support the CMS proposal to reverse the previously finalized policies regarding evaluation and management (E/M) payments. Those policies would have resulted in a significant disconnect between the resource use and intensity of physician services and the compensation for those services, which could have threatened access to care for vulnerable populations. NHHA also supports CMS’s commitment to addressing the opioid crisis by proposing to implement the statutorily required payments for opioid treatment programs (OTPs) and proposing a new bundled payment model for certain substance use disorders.

However, the NHHA has serious concerns about other CMS proposals with the proposed rule. For example, we are concerned with the restrictive nature and burden being proposed on criteria for therapy assistant services. We also have concerns about the proposal to price Part B injectable/implantable drugs used in the bundle at average sales price (ASP) without the legally mandated 6% add-on.
Payment for Evaluation and Management (E/M) Visits

CMS finalized policies that would blend the E/M rate for levels 2-4 E/M visits in last year’s PFS rule that was scheduled to go into effect CY 2021. The NHHA was deeply concerned with this provision, as we commented strongly in opposition. The disconnect between intensity of physician services and resources used with the compensation for such services would have threatened access to care. We strongly support the CMS proposal to reverse this methodology and adopt the alternative to have separate payment rates for all E/M levels for new and established patients.

Proposed Payment Reduction for Specific Code Groups for CY 2020

CMS proposes to significantly reduce relative value units (RVUs) of certain CPT groups. This could limit access to these very important services. Significant decreases in such a small timeframe will impact physicians and hospitals that provide this critical care. We agree with the American Hospital Association’s (AHA) recommendation to phase in significant changes in payment rates over a longer period of time. Doing so would provide predictability and reliability for the providers. CMS should do this for any CPT code groups that are significantly reduced.

Medicare Part B Benefit for Opioid Treatment Programs (OTPs)

The NHHA appreciates CMS’s commitment to address the opioid crisis and attempt to strike a balance between the flexibility of the benefit and appropriate oversight. This benefit would fill a gap in care, but OTPs often have limited long-term effectiveness. It can be challenging for the average person suffering from OUD to keep up with weekly interactions. In addition, the focus of OTPs on OUD may make these programs less effective due to the fact that the minority of OUD patients are addicted to opioids only. Many are addicted to multiple substances such as alcohol or other drugs. The NHHA believes these provisions should have a positive impact on certain patients. However, we agree with AHA’s recommendation that CMS should investigate more comprehensive payment models that address a wider range of substance use disorders and focus on long-term recovery.

We are concerned about the proposal to price the Part B injectable and implantable drugs used in the bundle using ASP without the 6% add-on that is a required part of the payment for Part B drugs. CMS states that it believes “many OTPs purchase the drugs from manufacturers,” thus limiting what the 6% add-on covers (such as overhead). CMS has a legal obligation to include a factor for overhead and adequately justify any add-on less than the standard 6% with data. That obligation is not met by an unsupported assertion of belief.

Bundled Payments for Substance Use Disorders (SUD) under the PFS

The NHHA appreciates CMS proposal to establish bundled payments for the overall treatment of OUD for physicians outside of OTPs. We are concerned with the narrow scope of services that are limited to OUD. We urge CMS to utilize a broad strategy that will not leave behind others who suffer from addiction that is not opioid-related. NHHA recommends CMS should
consider amending the definition of this bundle to include office-based treatment for SUD instead of only OUD.

**Payment for Therapy Assistant Services**

The NHHA requests that CMS makes the proposed calculation less restrictive for determining which cases involving therapy assistants would be subject to a statutorily mandated 15% cut. The proposed methodology is too restrictive, and the resulting cut would reduce resources for medically necessary services, including those needed to ensure patient safety. Further, the resulting administrative burden would divert resources from patient care and conflict with the agency’s “Patients over Paperwork” initiative. We agree with AHA’s detailed position and urge CMS to not finalize the requirement.

**Advisory Opinions on the Application of Physician Self-Referral Law**

The NHHA supports the changes proposed by the agency regarding shortening the time CMS must respond to a request, simplifying the certification requirement, and expanding what parties can utilize an advisory opinion. CMS should expand the type of requests the agency would evaluate and address what the ramifications will be if CMS does not issue an opinion within a specified timeframe.

**Quality Payment Program – Merit-Based Incentive Payment System (MIPS)**

In the proposal, CMS looks to take MIPS in a drastically new direction by beginning to implement the MIPS Value Pathways (MVPs) in CY 2021 performance period. The NHHA strongly urges CMS to do more analyses and obtain more stakeholder input before proceeding with the MVP approach. CMS also proposes to add 10 more episode-based cost measures, make significant revisions to the 2 overall cost measures used, and continue raising the weight of the cost category by 5% a year until it reaches 30%.

We are concerned by the rapid increase in the number and weight of cost measures and ultimately urge CMS to not finalize the new cost measures or the increase in weight for the cost category.

NHHA supports several proposals such as maintaining a reporting period of any continuous 90-day period through CY 2021 performance year, retaining the Query of Prescription Drug Monitoring Program (PDMP) measure as a bonus measure for CY 2020, revisions to the hospital-based clinician exclusion, continuing to allow non-physician clinicians to reweight their scoring from Promoting Interoperability by not reporting any measures.

**Quality Payment Program – Advanced Alternative Payment Models (APMs)**

NHHA supports accelerating development/implementation of APMs that reward better, more efficient, coordinated and seamless care for patients. We believe the provisions should be implemented in a broad approach that allows for the largest opportunity for providers
who so choose to become qualifying participants in APMs. There needs to be more opportunity for providers who serve more dispersed and vulnerable patients to participate in APMs. New Hampshire is a rural state and rural providers lack the resources to make investments that would be needed to participate in the new models. Rural providers face challenges due to geographic location, low patient volume, aged infrastructure, and shortages in resources and workforce. The NHHA believes CMS should consider providers such as these when designing APMs to expand the opportunity for them to participate in advanced APMs.

Thank you for the opportunity to provide input on this proposed rule. In addition to the above, NHHA fully supports the detailed comments submitted by the AHA regarding the PFS proposed rule. If you have any questions, please feel free to contact me or Nick Carano, Director, Financial Policy and Reimbursement at (603) 415-4253 or ncarano@nhha.org.

Sincerely,

Steve Ahnen
President