AMERICAN
COLLEGE of
CARDIOLOGY

Heart House
2400 N Street, NW
Washington, DC 20037-1153
USA

202-375-6000
800-253-4636
Fax: 202-375-7000
www.ACC.org

December 31, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
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; Medicaid Promoting Interoperability Program; Quality Payment Program—Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program—Accountable Care Organizations—Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recover and Treatment (SUPPORT) for Patients and Communities Act [CMS-1693F, CMS 1693 IFC, CMS-5522-F3, AND CMS-1701-F]

Dear Administrator Verma:

The American College of Cardiology (ACC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the CY 2019 Physician Fee Schedule (PFS) final rule.

The ACC is the professional home for the entire cardiovascular care team. The mission of the College and its more than 52,000 members is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards and guidelines. The College operates national registries to measure and improve care, offers cardiovascular accreditation to hospitals and institutions, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications.

In this letter the College provides comments on three issue areas from the final rule. While consideration of these topics is complete for CY 2019

rulemaking purposes, the ACC believes it is important to formally provide additional feedback to CMS for consideration in future rulemaking on evaluation & management (E/M) payment policy, misvalued services, and direct practice expense inputs.

E/M Payment Policy

In the CY 2019 physician fee schedule proposed rule, CMS proposed several changes to documentation standards, payment policies, and payment rates for the office or other outpatient E/M services reported with CPT codes 99202-99205 for new patient visits (Levels 2-5) and 99212-99215 for established patient visits (Levels 2-5). These proposals generated great interest and response from stakeholders, including ACC. Some proposals were finalized, some were not finalized, and others were revised and finalized for 2021.

As indicated in comments on the proposed rule, the ACC appreciates and supports the focus CMS brought to administrative burdens faced by clinicians in many areas through its "Patients Over Paperwork" initiative and other efforts. The College is pleased to see CMS finalize several documentation changes for CY 2019. These changes are an improvement and the ACC thanks CMS for moving to implement them:

- Eliminating the requirement for clinicians to re-document information in the medical record previously entered by ancillary staff or the beneficiary,
- Accepting documentation of the changes in the interval between visits as an alternative to "history of present illness" or "current symptoms;"
- Eliminating duplicative requirements for notations in the medical record by teaching physicians for E/M services, and
- Eliminating the requirement for additional justification for provision of a home visit rather than an office visit.

The ACC also thanks CMS for not finalizing other E/M proposals, specifically for not implementing a multiple procedure payment reduction policy for services provided on the same day as an E/M visit. The ACC commented in opposition to this proposal earlier this year and continues to believe such a policy would duplicate reductions that are already factored into code valuations and contradict longstanding policies that appropriately allow such services to be billed together without additional reduction in certain circumstances.

Finally, the ACC appreciates that CMS modified its proposal to implement a single payment amount for new patient visits 99202-99205 at a level that is between the current payments for 99203 and 99204, and a single payment for existing patient visits 99212-99215 that is between the amounts for 99213 and 99214 to leave level-5 visits intact and delayed these changes until 2021. CMS also delayed the option to document to a level 2 visit and choose medical decision-making only or

face-to-face time as determining factors until 2021. However, the College still believes the approach finalized for 2021—a single payment for 99202-99204 and a single payment 99212-99214—will negatively impact beneficiaries and clinicians.

Medicare beneficiaries may also be impacted should practices be forced to adapt to lower payments. By reducing the payment amount for level-4 visits, CMS undervalues instances when clinicians spend longer amounts of time treating and managing complex patients. The finalized payment construct assumes that the evaluation of low-level complaints is equal or similar to the management of severe and advanced cardiovascular disease. This is true even when including the new add-on codes. A response to this change in payment structure could be for patients to make additional visits.

Redistribution of resources will absolutely occur under this proposal. While CMS estimates the overall impact to cardiology at -2%, it will be terribly disruptive to many individual practices focused on the care of complex patients. For example, cardiologists with practices focused on managing complex heart failure patients, patients with rhythm disorders at risk for stroke, and geriatric cardiology specialists managing frail cardiovascular patients with multiple comorbid conditions generally bill a disproportionate number of high-level E/M visits in comparison to their peers. Internal modeling suggests that many of these individuals and practices will experience more than a 20-percent reduction in their E/M payments, even when incorporating the specialty and prolonged service add-on codes. These are not necessarily the same group of individuals as impacted by the initial proposal, but large payment swings remain on the horizon for many.

CMS notes this timeline allows the Agency to respond to the work done by the American Medical Association and the CPT Editorial Panel to revisit coding for E/M office/outpatient services. The ACC continues to support the progress of the Joint CPT/RUC Workgroup and remains optimistic stakeholders will develop innovative solutions that can achieve CMS's and stakeholders' shared goal of reduced documentation burden without negatively impacting clinicians the way ACC fears the initial and revised payment proposals would do. **It is paramount that CMS be willing to adopt workable alternatives developed by the Workgroup or further refine its own proposals in future rulemaking.**

Direct Practice Expense Inputs

CMS finalized a proposal to implement the recommendations of its contractor to update pricing for direct practice expense supply and equipment inputs over a four-year phase-in period, but made changes to approximately 60 inputs for CY 2019. The ACC thanks CMS for repricing these inputs after hearing stakeholder concerns about validity of specific recommendations in the report. CMS indicates some of these adjustments resulted in using the current price for inputs pending additional analysis and research.

The ACC continues to be concerned about the contractor's apparent reliance on a database that mostly captures the prices *hospitals* pay for these items. Physician practices do not typically hold the same bargaining and purchasing power that hospitals and hospital systems can deploy when negotiating prices for these inputs. **The ACC urges CMS to continue accepting new information from stakeholders during this comment period and beyond, updating inputs as appropriate in future rulemaking.**

Two pricing adjustments CMS revised after feedback that the changes would have significantly, negatively impacted cardiology practices and patients are the general ultrasound room (EL015) and the vascular ultrasound room (EL016). These inputs are integral components of the total practice expense payment for echocardiography and ultrasound services provided by cardiologists. The original contractor recommendations reduced room prices by 65% and 57%, respectively. Since the room is the main cost of providing these services, practice expense payment to physician practices would have been cut roughly 40%. The ACC has attempted to collect pricing information for the components of the room to give CMS additional information. Hopefully such information can be used to maintain current pricing or, at a minimum, implement reductions that are informed by pricing data from physician practices rather than hospitals.

Attached to this comment letter are three documents that include one or several components of a room. The three quotes indicate an average cost of $195,514 for the ultrasound machine, 50% more than CMS previously proposed for the entire ultrasound room. Quotes #2 and #3 also include upgrades that contain additional software and hardware options typical of the room, but these prices are not individually itemized. The ACC acknowledges these are quotes, not invoices, but understands from members who provided this information that these are the prices that were ultimately paid for these items. At a minimum, this information further illustrates the proposed prices for the rooms is incorrect and inadequate. The ACC will continue efforts to identify additional pricing information that can be shared, including invoices. As CMS and its contractor understand, this information is difficult to obtain. Additionally, the various items included in a room are typically obtained in a piecemeal fashion at different points in time, further complicating the effort.

Potentially Misvalued Services

CMS finalized seven codes identified through its public nomination process as potentially misvalued. Consistent with its initial comments on this topic, the ACC disagrees with this decision for both procedural and logical reasons and raises issues it believes CMS should further consider when it receives future public nominations of potentially misvalued services.

The Agency has broad discretion in how it executes its potentially misvalued service reviews. However, in this instance the ACC contends defined procedures were not

followed. CMS defined a process for public nomination of potentially misvalued services in CY 2012 rulemaking. Discussion of the public nomination process at 76 FR 73058 states, "after we receive nominated codes *during the 60-day comment period* following release of the annual PFS final rule with comment period, we would review the supporting documentation and *assess whether they appear to be potentially misvalued* codes appropriate for review under the annual process." These steps were not taken with this nomination.

The nomination was not provided during the 60-day comment period following release of the annual PFS final rule. (Elsewhere in CY 2012 rulemaking CMS highlighted that commenters wanting to review nominated codes need not worry because, "all timely comments received on the final rule with comment period can be accessed and reviewed by the public through http://www.regulations.gov/ after the final rule's comment period closes. Therefore, anyone who wishes to look though the public comments can identify the codes that have been nominated by the public as potentially misvalued, as well as the accompanying supporting documentation.") Stakeholders now know the nomination was provided in February, and never available for the sort of review CMS stated could occur.

CMS also did not assess whether the nominated codes appear to be potentially misvalued and subject to additional review. A brief summary of a nomination was provided, but the codes were not assessed and "proposed" as potentially misvalued. (83 FR 35733) In contrast, during CY 2018 rulemaking, at the end of its discussion of nominated codes, CMS stated it was "proposing these codes as potentially misvalued so that they can be reviewed again." (82 FR 33978)

CMS missed an opportunity to exercise transparency and restraint by publishing more information in timely fashion and determining that the nominated services are not potentially misvalued and warrant no further scrutiny at this time. The ACC believes stakeholder responses would have been more comprehensive had CMS followed its stated process, and a different decision should have been reached to not finalize these services as potentially misvalued.

The decision to finalize these services as potentially misvalued is particularly frustrating in one instance, code 93006 for transthoracic echocardiography. The data from the Urban Institute report cited by the nominator stem from five clinician interviews and 20 empirical observations. One report author recently stated during a November 27, 2018 presentation at the American Enterprise Institute that the report was, "a feasibility study of how to get empirical data, not to rely on the results obtained." The most recent survey of this code by the RUC in 2016 contained responses from 172 physicians who provide the service. The specialized clinical experience of respondents and volume of responses makes the recent RUC survey more accurate in the eyes of the ACC. Compounding that frustration is the fact that CMS finalized the current values for 93306 *one year ago*. In fact, it had both the Urban Institute report and recommendations from the RUC in hand when it did so. The ACC disagrees that anything changed to suggest 93306 is potentially misvalued

between CMS's decision to finalize the current values in November 2017 and its decision to finalize it as potentially misvalued in November 2018. The only new development is that the service was nominated by a member of the public outside of the public nomination process.

That raises the last aspect of this nomination that CMS must consider carefully for the future. The decision by Anthem, Inc., a health insurance company, to nominate codes as potentially misvalued opens a new chapter in this process. Certainly, as a member of the public, the public nomination process is meant to be available to Anthem. However, in Anthem's February 9, 2018 nomination letter, they state that, "systematic overvaluation of work plagues the Medicare FPS (sic)…" How much further might the Agency go to ferret out this plague? It is difficult for the public to know because no assessment was made regarding the validity of the nomination during the process. The ACC is concerned that Anthem and potentially other private payers may use the CMS process as a mechanism to reduce their own payment rates.

The ACC urges CMS to closely follow its defined public nomination process in the future, and to carefully consider the imbalances it may create by engaging in a partnership with a private insurance company to address the company's concerns about payment rates. Anthem already has a mechanism to address its payment rates to providers—it can negotiate appropriate rates in the marketplace. This is an option ACC members do not have when they care for Medicare patients.

Conclusion

Thank you for considering the College's comments on these three topics as the agency begins collecting information and ideas for future rulemaking. The ACC appreciates CMS's willingness to hear constructively critical feedback and looks forward to ongoing engagement. Should you or staff need additional information or have clarifying questions, please contact James Vavricek, Associate Director for Regulatory Affairs, at jvavricek@acc.org.

Sincerely,

C. Michael Valentine, MD, FACC
President

Attachments