October 2, 2020

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

Re: Medicare Program: CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc. [CMS-1734-P]

Dear Administrator Verma:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposals in the Calendar Year 2021 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. CMS has proposed substantial changes to the Medicare Shared Savings Program (MSSP), Merit-Based Incentive Payment System (MIPS), and Quality Payment Program that we appreciate and support. However, we have numerous recommendations and suggestions that we feel will only serve to strengthen these programs and the overall movement from volume to value.

About America's Physician Groups

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care for nearly 45 million patients. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the outcomes of the care provided. Our preferred model of accountable, risk based, and coordinated care avoids incentives for the high utilization associated with FFS reimbursement. APG member organizations are also working diligently to rise to the challenge presented by the COVID-19 pandemic, and we appreciate the flexibilities and waivers CMS has afforded us during this time of crisis.

Summary of APG's Comments

Medicare Shared Savings Program

- **Continue to utilize the Web Interface reporting for another year while phasing in a new quality reporting system to give ACOs sufficient time to implement a new reporting method**
- **Reconsider proposal to use the performance period benchmarks to score quality measures for 2021 instead of the historical benchmark**
- **Maintain the APM Scoring Standard and not implement the proposed APP until 2022**
- **Solicit stakeholder input to create a more appropriate APP measure set**
- **Maintain the APM Scoring Standard and not implement the proposed APP**
- **We would recommend that CMS implement another method of setting benchmark such as a blend of previous year quality scores rather than using the performance year to set the benchmark**
- **We would recommend that CMS returns to a domain type policy like a percent of the measures need to meet at least 40th percentile rather than a cliff type policy.**

Telehealth and Other Services Involving Communications Technology

- **Support for the creation of the Category 3 criteria and all other proposed additional codes.**
- **Expand audio-only telehealth services under Communication Based Technology Services with adequate reimbursement**
- **Expand the ability of providers and/or payors to provide patients with the components for audio/visual technology and extend eligibility for risk adjustment payment to telehealth services conducted solely through audio only technology**
- **Support for the adoption of the actual total times rather than the total times recommended by the RUC for CPT codes 99202-99215**
- **Support for the addition of nine codes to the telehealth services list on a permanent basis, including codes GPC1X and 99XXX**
- **Support for the proposed revision allowing direct supervision to be provided using real time, interactive audio/video technology (excluding audio-only) through the latter of the end of the calendar year in which the PHE ends or December 31, 2021**
- **Account for patient attribution in telehealth services to ensure providers receive proper accounting for their patients**

Scope of Practice

- **Oppose making Pharmacists practice under incident-to regulations**

Care Management Services and Remote Physiologic Monitoring Services

- **Consider removing the self-reported data restriction due to the realities of patients' relationships with technology**

- **Support CMS' view that payment for RPM for both chronic and acute conditions is appropriate and agree with the proposal as it currently stands**

Transitional Care Management (TCM)

- **Support for CMS' proposal to allow HCPCS Code G2058 to be billed concurrently with TCM when reasonable and necessary**

Recommendations

Medicare Shared Savings Program

Replacing the APM Scoring Standard with the APP
CMS has proposed a new program which will substantially change the current MIPS APM Scoring Standard by replacing it with the APM Performance Pathway (APP) to align with Quality Performance Program. The APP would apply one set of quality measures for all APMs subject to MIPS, requiring each model participant to report both their APM's specific quality measures and the APP quality measures as well. We appreciate and endorse moving to one quality standard for all APMs. However, at this time, it is our view that this one size fits all approach represents an additional burden for APM participants due to the national public health emergency. As a result, **we ask that CMS maintain the current MSSP APM Scoring Standard and not implement the proposed APP until 2022**.

APP Measure Set
CMS proposes significant changes to the quality measure set ACOs must report under the new APP with reducing 6 quality measures as opposed to 23 which we support the focus on reducing reporting burden. We feel that increased stakeholder input is needed so a more appropriate APP measure set can be drafted. **We urge CMS to gather stakeholder input to draft such a measure set.** Open stakeholder forums, requests for information, or other venues such as the Measure Applications Partnership (MAP) are all viable venues for feedback that will ensure a more accurate set of measures. Additionally, having a highly volatile readmission measures will count more toward providers' quality scores, making their inclusion in measuring quality concerning with so few total measures used.

Removal of the Web Interface Reporting Option
CMS has proposed to stop using the Web Interface reporting mechanism for ACOs, used to support quality measure data collection and submission. We have numerous concerns over the removal of this reporting option which is heavily preferred by Medicare Shared Savings (MSSP) and Next Generation ACOs, with so little notice. We would request that CMS provider greater clarity on the expected use of alternative MIPS reporting options, such as MIPS CQMs and eCQMs. The use of these reporting mechanisms could result of inaccurate evaluation of ACOs quality performance based on the total patient population instead of patients assigned to an

ACO as the rule intended. In addition to wrongful attribution, ACOs may have issues with accessing patient data for those patients not assigned to them, skewing any assessment of quality.

In light of the required investments for ACOs transitioning to comply with eCQM standards, **we ask that CMS adopt a more phased-in approach that moves quality reporting away from the use of the Web Interface reporting option toward any proposed alternatives**. At a minimum, **the Web Interface must be continued for at least one additional year to give ACOs sufficient time to implement a new reporting method**.

<u>Proposed Quality Measures Benchmarks</u>
CMS has proposed using the performance period benchmarks to score quality measures for 2021 instead of the historical benchmark due to irregularity of PY2020 due to COVID-19. This will lead to participants not knowing benchmarks until after performance period is completed which disadvantages the participants. We would recommend that CMS implement another method of setting benchmark such as a blend of previous year quality scores.

<u>Shared Savings Program Quality Performance Standard</u>
CMS also proposes increasing the Shared Savings Program quality standard by raising the current minimum attainment level from 30th percentile of at least one measure in each of the 4 domains to the 40th percentile in aggregate for all MIPS Quality measures reporters, excluding providers eligible for facility-based scoring. While the proposal surrounding maximum savings after achieving a quality threshold is positive overall, we have concerns regarding the increase from the 30th percentile of the one measure in each domain to 40th minimum percentile in aggregate in quality performance. **While comparing ACOs to all MIPS performers may seem reasonable on the surface, our members are very concerned about the all or nothing (cliff approach) that could have major implications to sustainable of the model. The financial implications for ACOs are much higher than MIPs participants and other policies should be considered. We would recommend that CMS returns to a domain type policy like a percent of the measures need to meet at least 40th percentile.**

<u>Telehealth and Other Services Involving Communications Technology:</u>

<u>Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List</u>
CMS has proposed the creation of a third category of criteria for adding services to the Medicare telehealth list on a temporary basis. CMS would include in this category services added during the PHE for which there is likely to be clinical benefit when furnished by telehealth but do not meet the requirements under Category 1 or Category 2. **We believe that the agency's decision to create a third category for adding new services to the Medicare telehealth list is an appropriate way to extend coverage to specific services while still maintaining safety and clinical effectiveness standards. We support the creation of the Category 3 criteria and all other proposed additional codes.**

Medicare Telehealth Services

APG appreciates CMS's efforts to expand access to telehealth, particularly as stakeholders attempt to grapple with the ongoing COVID-19 public health emergency (PHE). CMS is proposing to make some of these regulatory flexibilities permanent. These flexibilities resulting from the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act legislation have greatly assisted physician practices and hospitals in providing treatment for those patients in need, flattening the pandemic curve, and relieving the financial pressures they have faced while serving their communities, with telehealth being of particular importance. Providers have had to adapt to the reality of the COVID-19 pandemic by transitioning up to 70 percent of care toward telehealth services. Some of our member organizations that reported no virtual healthcare visits prior to the COVID-19 pandemic, found those virtual E/M and annual wellness visits dramatically increasing once the outbreak began. With the new telehealth flexibilities passed during the PHE, one APG member organization has provided over 30,000 telehealth visits for seniors enrolled in Medicare Advantage plans, representing 40 percent of the total primary care visits that were performed during the pandemic. Of the patients they treat through telehealth, 15 percent suffer from more than four chronic conditions. Another organization reports 113,299 video visits with 43,102 telehealth visits completed in April, comprising 73 percent of all visits for that month. They have also utilized telehealth to provide patients with convenient access to care by conducting 1,100 video visits after hours and during weekends through a system that places patients in a queue where they will be seen by physicians as they become available. Of these after-hours visits, 474 patients were deemed by the triage system to require an in-person visit within 4 hours, and all were seen. The expansion of telehealth services has had the added benefit of allowing the chronically ill to continue to receive the care they need while avoiding the risks presented by COVID-19.

The advantages that telehealth services represent for those patients with issues surrounding access to care, individuals with disabilities, and the elderly have been noticed not just by providers, but by patients themselves. Telehealth services hold particular importance for patients living in rural areas of the country for whom travel has always been difficult, even before the adoption of widespread social distancing. The recent expansion of telehealth has allowed patients to maintain contact and receive care from their physicians in locations that are convenient for them. In a survey of its patient population, one healthcare provider found that over 90 percent of respondents reported being "highly satisfied" or "satisfied" with their virtual visit. 82 percent of patients who had a telehealth visit believed that the care provided was as good, or better than, an in-person visit.

As CMS continues to work toward strengthening telehealth services, **it is imperative that we resolve the outstanding issues and barriers still in place for providers and their patients. Expanding access to smartphone and internet technologies, expanding the ability of providers and/or payors to provide patients with the components for audio/visual technology, or extending eligibility for risk adjustment payment to telehealth services conducted solely through audio only technology such as landlines are all viable options in strengthening access for patients and ensuring that they receive all necessary care. We understand that CMS is limited in expanding telehealth beyond the PHE due to their limited authority, however we appreciate their commitment to explore other avenues.**

Attribution for Telehealth Services

As the availability of telehealth services is expanded, **we would also ask CMS to consider any potential effect the increase of these services could have on patient attribution for providers.** Attribution is one of the most critical components of value-based care. Through patient attribution, responsibility for the quality and costs of the care delivered to that patient for a specific performance period and under value-based contracts, the patient attribution process defines a provider's risk pool, influences medical loss ratio, and determines whether a provider will realize shared savings or losses and how those funds or penalties are allocated. As patients seek telehealth services from providers at their own convenience, the potential for care to be given to patients by providers who specialize exclusively in telehealth and do not have an ongoing longitudinal relationship with a primary care physician is high. As a result, these telehealth-only providers could possibly conduct services such as virtual annual wellness visits that would not be properly attributed and disrupt the continuum of care and attribution data as a result. **It is important to ensure that patients are accurately assigned to their providers, even if the patient seeks care from other doctors.**

Communications Technology-Based Services:

New Codes

CMS has proposed adding two additional HCPCS G codes, G20X0 and G20X2, for Communications Technology-based Services (CTBS) services for billing by providers who cannot independently bill for E/M services. These new codes would be valued identically to the G2010 and G2020 codes for CTBS services provided by physicians or other qualified health care professionals. **Extending these new codes for those providers who care for patients under similar conditions as other physicians but lack the ability to bill for them is a proposal that we support.**

Audio-health

In the proposed rule, CMS also has asked for comments on whether it should develop coding and payment for a service similar to the existing virtual check-in codes but for a longer unit of time and with higher value. **We have long advocated for the expansion of audio-only telehealth services and for recognizing their value for patients and physicians alike however it is essential that adequate reimbursement is set.** According to a recent study published in JAMA, 25 percent of seniors lack access to high-speed internet or smartphones. During the pandemic, providers have reported that many of their senior patients are unable to figure out high-end smartphone technology and have instead opted to use audio-only phone calls. Other patients have had to travel to local fast-food restaurants in order to access wireless internet connections. Audio-only telehealth provides the same quality care as in-person visits with the access to the same care such as prescription medicine and lab services. This should be taken into consideration when contemplating reimbursement at a level higher than typical for CTBS.

Direct Supervision by Interactive Telecommunications Technology

CMS has proposed revising current regulations to allow direct supervision to be provided using real time, interactive audio/video technology (excluding audio-only) through the latter of the end of the calendar year in which the PHE ends or December 31, 2021 and subject to the

clinical judgement of the supervising physician or other supervising practitioner. **We support CMS' proposal.**

Refinements to Values for Certain Services to Reflect Revisions to Payment for Evaluation and Management (E/M) Visits:

Time Values for Levels 2-5 Office/Outpatient E/M Visit Codes
CMS has proposed adopting the actual total times (defined as the sum of the component times) rather than the total times recommended by the RUC for CPT codes 99202-99215. **We support the proposal as offered in the proposed rule.** Listing the times set for each level and removing the requirement that half of the time spent with patients must be face-to-face will work to simplify the process for physicians who have traditionally shied away from using time and encourage increased usage now that the process will be simplified.

Prolonged Office/Outpatient E/M Visit Reporting
CMS proposes the addition of nine codes to the telehealth services list on a permanent basis, of which GPC1X, covering visit complexity, and 99XXX covering Level 5 prolonged service time were included. This proposal is fundamentally of benefit to primary care physicians. Specialties such as endocrinology and neurology have historically hesitated to use 99215 as a code but may be motivated to change this strategy by the move to total time that will simplify things for them. **We support this proposal.**

Scope of Practice and Related Issues:

Pharmacists Providing Services Incident-to Physicians' Services
CMS reiterated the clarification it made in the May 1st Interim Final Rule with Comment Period that pharmacists are captured by the regulatory definition of auxiliary personnel, allowing pharmacists to provide incident-to services under the appropriate level of supervision of the billing physician or NPP, consistent with state scope of practice and applicable state law. If payment is made for those services under Part D, the services may not be reported or paid under Part B. **We oppose this proposal as pharmacists should not be made to practice under incident-to regulations.** As long the services that pharmacists render is offered as part of care provided under primary care physicians or within a medical home, there are numerous services that pharmacists are able to provide on their own and contributes to care redesign.

Care Management Services and Remote Physiologic Monitoring Services:

Digitally Stored Data Services/Remote Physiologic Monitoring/Treatment Management
In the proposed rule, CMS clarified that the medical device should digitally upload patient physiologic data, emphasizing that this means the physiologic data is automatically uploaded and not data that is patient self-reported. The device must be used to collect and transmit reliable and valid physiologic data that allows evaluation of a patient's health status for development and management of a treatment plan. **We ask that CMS consider removing the self-reported data restriction due to the realities of patents' relationships with technology.** Not all devices used are connected with each other, making the gathering of data more fraught than the proposal takes into account. Many senior patients also have issues with the usage of

technology and their connection, as evidenced in the increase of audio-only technology services. The proposal in its current form fails to acknowledge that the purpose of remote monitoring is not technological integration, but the ability to monitor patients in real time in order to offer the best care possible.

CMS also stated in the proposed rule its view that RPM can be used for both chronic and acute conditions. **We support the agency's view that payment for RPM for both chronic and acute conditions is appropriate and agree with the proposal as it currently stands**.

Transitional Care Management (TCM)

In the proposed rule, CMS identifies 15 additional codes that can be billed concurrently with TCM, including 14 codes for end-stage renal disease services and one complex chronic care management service. **We support CMS' proposal to allow HCPCS Code G2058 to be billed concurrently with TCM when reasonable and necessary.**

Conclusion

Thank you for your attention to the above comments. It is important that CMS continues to work with stakeholders to strengthen Medicare and incentivize the move toward value. We look forward to a final rule that accomplishes these goals. Please feel free to contact Valinda Rutledge, Senior Vice President, Federal Affairs, (vrutledge@apg.org) if you have any questions or if America's Physician Groups can provide any assistance as you consider these issues.

Sincerely,

Donald H. Crane
President and CEO
America's Physician Groups