September 13, 2021

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

Ms. Chiquita Brooks-LaSure
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; CY2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1751-P]**

Dear Administrator Brooks-LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposals in the Calendar Year 2022 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.

**<u>About America's Physician Groups</u>**

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 170,000 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.

**<u>Summary of APG's Comments</u>**

## Medicare Shared Savings Program

- **We support the extension of the Web Interface portal, as suggested in our CY2021 Medicare Physician Fee Schedule comments but recommend that CMS continue with a prolonged, phased-in approach beyond the 2 year proposed extension.**
- **CMS should refrain from applying all-payer measures to Medicare shared savings/loss determinations**
- **We recommend that CMS further delay eCQM reporting until EHR vendors are able to ensure interoperability**
- **CMS should use CHART modeling and direct contracting entity (DCE) language to incentivize movement by organizations into distressed communities in partnership with the agency**
- **CMS should use fewer and more simple measures and allow organizations to have a reporting only period before being measured on health disparities**
- **CMS should delay measuring organizations on health disparities to allow them more time to make the proper investments in treating underserved communities**
- **We support the proposal to allow ACOs to report quality data at the TIN level, providing that this method would be optional and not required**
- **CMS and CMMI provide all reports at TIN level (especially the Performance Year Expenditure reports and the Benchmark Year Expenditure Reports) so that organizations can identify which practices within alternative payment models need to improve cost-utilization**
- **Reporting options for specialists within ACOs should be the same as those used by other providers within ACOs**
- **Favor CMS allowing for TIN-NPI participation rather than requiring all NPIs billing under a given ACO participant TIN to be in the ACO**
- **CMS should implement a policy for regional fee-for-service benchmarking that is like what is currently being utilized in the direct contracting model**
- **CMS should explore increasing the weight of regional benchmark**

## Telehealth and Other Services Involving Communications Technology

- **CMS should reconsider its requirement that providers conduct an in-person visit within six months of an initial telehealth mental service**
- **In crafting the language surrounding an in-person, non-telehealth visit prior to the mental telehealth visit to be furnished by a different practitioner in the same specialty/subspecialty in the same group, CMS should provide flexibility by implementing relaxed language that accounts for those organizations who work with outside behavioral health groups.**
- **Regarding the need for additional documentation for telehealth services or the exclusion of higher-level services from audio-only telehealth, CMS should avoid including too many restrictions on audio-only telehealth services that would hamper providers' ability to use them. The current documentation guidelines provide**

**adequate structure to document the need for the level of service provided and anything further would be anathema to the goal of reducing the paperwork/documentation burden inherent in our healthcare system**

- **CMS should allow audio-only telehealth to be an option for counseling services**
- **The virtual supervision of services that allows for "direct supervision" to include being immediately available using real-time interactive audio/video communications technology should be made permanent**

## Evaluation and Management (E/M) Visits

- **The new split (shared) visit policy presents an added burden for providers without offering any additional value to care**
- **CMS should decline to delve into further defining the term "group" under split visit billing and instead wait until the split visit policy has been implemented for some time and providers/organizations have become acclimated to it**

## Vaccine Administration Services

- **CMS should classify mobile vaccination as "home" so that organizations are reimbursed for their financial investment in safe vaccination**

## Recommendations

### Medicare Shared Savings Program

Removal of the Web Interface Reporting Option

CMS is proposing to extend the CMS Web Interface reporting option for an additional two years. For the 2022 performance year, CMS is proposing to allow MSSP accountable care organizations (ACOs) to report the 10 CMS Web Interface measures or report the three Alternative Payment Model Performance Pathway (APP) electronic clinical quality measure (eCQM)/Merit-based Incentive Payment System (MIPS) CQMs. For the 2023 performance year, ACOs would be required to report either the 10 CMS Web Interface measures and at least one APP eCQM/MIPS CQM or report the three APP eCQM/MIPS CQMs. Beginning with the 2024 performance period and subsequent years, ACOs will be required to report the three APP eCQM/MIPS CQMs.

In light of the required investments for ACOs transitioning to comply with eCQM standards, **we applaud CMS' decision to extend the usage of the Web Interface but we encourage a more phased-in approach**. Continuing the Web Interface for two additional years does not give ACOs sufficient time to implement a new reporting method.

While the extension will help organizations in transitioning to APP, we would also caution that **CMS should refrain from applying all-payer measures to Medicare shared savings/loss determinations in general**. The impact for ACOs in the highest risk tracks is much more

substantial than what would be faced for MIPS reporters aiming for a small increase in their FFS reimbursement or avoiding a small cut through their quality performance. MSSP ACOs are signing a risk-based contract with Medicare for a specified population of eligible, assigned Medicare FFS beneficiaries. Tying this risk-based contract to quality results on patients under other provider-payer contracts that are completely outside the scope of the ACO's contract with Medicare is a misguided policy decision with widespread ramifications. This policy could also result in ACOs/participants being penalized or rewarded twice, where privately insured patients may be under other risk contracts that include quality measures. If the agency were to implement a MIPS-like payment incentive for the other-payer measures outside of shared savings/loss determinations this would make sense otherwise, other-payer measures should be pay-for-reporting only. A significant hurdle would still exist in getting data aggregated across TINs for eCQM reporting, even in the longer transition period, but at least ACO Medicare savings/losses would be tied to Medicare quality outcomes.

We appreciate the movement toward electronic quality measures which reduces reporting burden with the use of eCQMs. However it continues to be technically difficult to operationalize due to interoperability issues among different EHRs, thus we recommend that CMS further delay eCQM reporting until vendor implementation of intraoperability is completed.

<u>Solicitation of Comments on Feasibility of TIN Level Reporting and Sampling for eCQMs/MIPS CQMs</u>

CMS is seeking comment on allowing ACO providers/suppliers to submit eCQMs/MIPS CQM measures to CMS at the ACO participant TIN level with CMS then calculating/aggregating the TIN level quality data to create an ACO level score. Alternatively, CMS could calculate an ACO-level numerator for each measure and an ACO-level denominator, then divide the two x 100 to obtain the ACO-level performance rate. CMS seeks comment on these two potential approaches as well as any other suggested approaches to the aggregation of ACO participant TIN level quality data at the ACO level.

**We would support the proposal to allow ACOs to report quality data at the TIN level, providing that this method would be optional and not required.** This approach may not significantly reduce reporting burden for ACOs, particularly if ACOs must de-duplicate numerator and denominator data at the patient level; however, some ACOs may prefer to have TIN-level reporting available as an option. **We also suggest that CMS and CMMI provide all reports at TIN level (especially the Performance Year Expenditure reports and the Benchmark Year Expenditure Reports) so that organizations are able to identify which practices within alternative payment models need to improve cost-utilization**.

<u>Comment Solicitation for Reporting Options for Specialist Providers within an ACO</u>

After hearing from stakeholders that the population health/primary care focused measures in the APP are not applicable for specialist providers within an ACO, CMS sought input on the role specialists play in ACOs and what specialty measures in the current eCQM or MIPS CQM measure set should be considered for inclusion in the Shared Savings Program quality measure set in future performance years.

**We suggest that reporting options for specialists be the same as those offered to and used by other providers within ACOS.** Adding specialist measures or requiring TINs to report outside of the ACO would be particularly problematic for multi-specialty groups, where a large segment of a given TIN might be primary care and another segment might include specialists in one or more specialties. Therefore, having them report at a TIN level as though all are specialists would not make sense. The agency must also consider that not all specialists are alike. For instance, some may contribute significantly to ACO attribution, population health outcomes, total cost of care, etc. while others less so. One often overlooked incentive of participation in an ACO is that the ACO takes the bulk of the reporting burden off the backs of the practices, so they can focus more on patient care. We would also argue that the current ACO measure set is appropriately designed to capture population health in conjunction with total cost of care metrics.

**A uniform reporting system will ensure a better reporting process for ACOs and providers that will run more smoothly for both stakeholders and the agency.** Ensuring that a seamless reporting process is implemented that avoids excessive administrative burden and labor intensity will allow providers to spend more time managing patient lives rather than filling in an arduous amount of paperwork and ensuring that contracts are properly managed.

Finally, **we would favor CMS allowing for TIN-NPI participation rather than requiring all NPIs billing under a given ACO participant TIN to be in the ACO.** That would allow ACOs to curate the highest value network possible where all providers are actively engaged and working toward the same goals. Providers not in the ACO (e.g., specialists who wouldn't be contributing to attribution anyway), could then report quality via MIPS or other APM more appropriate to their specialty such as bundled payment or disease-specific models. CMS could consider making this TIN-NPI participation option applicable only to the ENHANCED Track as an incentive to move to more significant levels of two-sided risk.

<u>Request for Comment on Calculation of the Regional Adjustment and Blended National Regional Growth Rates for Trending and Updating the Benchmark</u>
In its proposed rule, CMS stated that it has begun to analyze concerns about the use of factors based on regional fee-for-service (FFS) expenditures in calculating ACO benchmarks. and to consider possible modifications to the Medicare Shared Savings Program's benchmarking methodology to ensure the sustainability of the program's financial models. The agency requested comment on suggested approaches to modifying the program's benchmarking methodology.

APG believes that CMS should examine risk adjustment methodology in general and analyze how fairly it is applied within both Medicare Advantage and traditional Medicare. **We suggest that CMS implement a policy for regional FFS benchmarking that is like what is currently being utilized in the direct contracting model**. Utilizing this method would work to ensure that CMS and the Center for Medicare and Medicaid Innovation would add back direct contracting entity or ACO savings in the regional FFS expenditures. Doing so would prevent ACOs from

competing against themselves as the regional FFS expenditures are already lowered by the ACO driven savings. Direct Contracting also factors in the Medicare Advantage (MA) regional benchmark which works to address programmatic concerns about disparities between MA and traditional Medicare. **Increasing the weighting of the regional benchmark is an additional option that the agency should explore.** APG would like to be a good partner moving forward in the effort to make changes to this methodology.

Solicitation of Comments on Addressing Health Disparities and Promoting Health Equity
CMS is seeking comments and recommendations on how ACOs can utilize their resources to ensure that patients, regardless of racial/ethnic group, geographic location and/or income status, have access to equal care and how ACOs can improve the quality of care provided to certain communities, while addressing the disparities that currently exist in healthcare. The agency is also requesting comments and recommendations on how it can encourage health care providers serving vulnerable populations to participate in ACOs and other value-based care initiatives, including whether any adjustments should be made to quality measure benchmarks to consider ACOs serving vulnerable populations.

The issue of addressing health disparities represents a new frontier of work for most healthcare organizations and we salute CMS for the priority on reducing health disparity. However, it will require substantial new methods of measurement into ACOs work as well Impacting health equity will also require considerable financial and resource investment by these organizations into underserved and underrepresented communities. Because of the time needed to properly implement and account for this work, **we suggest that CMS begin the implementation of measuring organizations on health disparities by collecting data on a standardized data as the industry determines which interventions are effective.**

As the agency continues its work on the issue, **we suggest that once these measures are ready for implementation, CMS should use CHART modeling and direct contracting entity (DCE) language variant to incentivize movement by organizations into distressed communities in partnership with the agency. We also suggest using fewer and simpler measures would work within a period where organizations would simply report first before fully engaging in being measured on this front.**

## Telehealth and Other Services Involving Communications Technology

Implementation of Provisions of the Consolidated Appropriations Act, 2021 (CAA)
CMS has proposed requiring providers to conduct an in-person, non-telehealth service within six months prior to providing an initial telehealth mental health service, and at least once every six months thereafter. CMS seeks comment on whether this proposal is feasible and/or appropriate, or if the agency should implement a different policy for scenarios where an in-person, non-telehealth visit prior to the mental telehealth visit is furnished by a different practitioner in the same specialty/subspecialty in the same group.

The agency's requirement that providers conduct an in-person visit with six months of an initial telehealth mental service will erect unnecessary barriers to care for many senior patients in an area of care where receiving treatment already has substantial challenges in place. **We ask that CMS reconsider the implementation of this policy.** Both the agency and healthcare organizations are certainly in agreement that barriers to care should be reduced rather than reinforced and creating this arduous and unnecessary requirement would only serve to make treating mental health for Medicare beneficiaries more difficult than needed.

As for the agency's policy on a scenario where an in-person, non-telehealth visit prior to the mental telehealth visit is furnished by a different practitioner in the same specialty/subspecialty in the same group, **we ask that CMS consider the contractual agreements that many organizations have in place before codifying this requirement.** Many organizations have obligations with outside behavioral health groups who are not in-house, and therefore not all at same TIN level. **In crafting the language surrounding an in-person, non-telehealth visit prior to the mental telehealth visit being furnished by a different practitioner in the same specialty/subspecialty in the same group, CMS should provide flexibility by implementing relaxed language that accounts for those organizations who work with outside behavioral health groups.**

Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology

CMS is proposing to amend its regulations to specify that an interactive telecommunications system can include interactive, real-time, two-way audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder under the following conditions: (1) the patient is located in their home at the time of service; (2) the distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunications system that includes video and; (3) the patient is not capable of, or does not consent to, the use video technology for the service. The agency is seeking comment on these proposals and if any additional documentation, such as information about the patient's level of risk and any other guardrails that are appropriate to demonstrate clinical appropriateness and minimize program integrity and patient safety concerns, should be required in the patient's medical record to support the clinical appropriateness of providing audio-only telehealth services for mental health in the event of an audit or claims denial.

CMS is also seeking comment on whether it should exclude certain higher-level services (e.g. level 4 or 5 E/M visit codes) for the audio-only mental health telehealth services exception when furnished alongside add-on codes for psychotherapy, or codes that describe psychotherapy with crisis, and whether the full scope of service elements for these codes could be performed via audio-only communication technology.

Regarding both questions from the agency on the need for additional documentation for telehealth services or the exclusion of higher-level services, **we believe that the more restrictions included with audio-only telehealth services, the ability of providers to administer telehealth services is severely hampered, leading to the services essentially being**

**"approved" in spirit but not in practice.** In practical terms, it is unlikely for care to reach Levels 4 or 5 within E/M coding through audio-only, unless care is based on time. The time itself will limit what kind of service could be provided at any given time. **We also suggest that CMS allow audio-only telehealth to be an option for counseling services.**

Expiration of PHE Flexibilities for Direct Supervision Requirements
As part of the public health emergency (PHE), CMS established the virtual supervision of services, allowing for "direct supervision" to include being immediately available using real-time interactive audio/video communications technology. CMS has asked stakeholders if this change should be made permanent. **We agree with making this policy permanent and encourage CMS to move forward with this proposal.**

## Evaluation and Management (E/M) Visits

Split (or Shared) Visits
CMS is proposing to define a split (or shared) visit as an E/M visit in the facility setting (i.e., an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited by regulation) that is performed in part by both a physician and an NPP who are in the same group. The E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting. These split visits could be reported for both new and established patients, initial and subsequent visits, and for critical care and certain Skilled Nursing Facility/Nursing Facility E/M visits. CMS would allow only the physician or NPP who performs the substantive portion of the split visit to bill for the visit, with "substantive portion" defined as more than half of the total time spent by the physician and NPP performing the visit.

**We believe that this policy would present an added burden for providers without offering any additional value to care.** In some APG member organizations, there are instances in which a patient may schedule multiple visits with providers in the same day due to convenience in terms of facility, geographical location or gender preferences for portions of the evaluation. For example, a patient may be seen by their Internal Medicine Primary Care physicians and then subsequently need a pelvic examination that they prefer be done by a female Nurse Practitioner in the same group. This now requires the PCP to come back to the documentation later to review and then discuss with the NP which portion of this split visit was more "substantive." If there were three visits within the same provider group on the same day and only the provider with the most time receives reimbursement, the non-value-added administrative time would be substantial. **A better alternative could potentially be for the physician to reference the other services provided in his/her documentation and then bill for cumulative care.**

***Same Group***
CMS is seeking comment on whether it should further define "group" for purposes of split (or shared) visit billing, Including the options of requiring that the physician and NPP be in the same

clinical specialty using the approach outlined in the CPT E/M Guidelines, or aligning the definition of "group" with the definition of "physician organization."

**We would request that CMS decline to delve into further defining the term "group" under split visit billing.** Adding additional complications and new rules to such a new billing process that will already require a substantial amount of adjustment and learning from providers and their organizations is not conducive to a successful implementation of split billing overall. **A more phased-in approach over time after stakeholders have been able to learn the intricacies of the split visit process would be better for both CMS and organizations as a whole.**

## Vaccine Administration Services

<u>Comment Solicitation: Medicare Payments for Administering Preventive Vaccines</u>
CMS is requesting feedback from stakeholders that would support the development of an accurate and stable payment rate on a long-term basis for administration of the preventive vaccines for physicians, NPPs, mass immunizers and certain other providers and suppliers. Specifically, the agency asks what are the different types of providers and suppliers that furnish preventive vaccines, have these types of providers/suppliers changed as a result of the PHE for COVID19, what are the resource costs that physicians, NPPs, mass immunizers and certain other suppliers incur when furnishing vaccines safely and effectively, what are the impacts of the PHE for COVID-19 on resource costs incurred by vaccination providers, and do stakeholders envision that these impacts will continue after the PHE has ended?

**Over the course of the PHE, APG member organizations have found that the resultant lower staffing levels caused by the COVID-19 pandemic have negatively affected their ability to provide flu vaccine to help ease of access.** As staff is needed to operate COVID-19 clinics and some are unable to come to work due to symptoms or potential exposures, this has pulled them away from being able to run and fully staff influenza clinics simultaneously. As a result, many organizations have reported a decreased number of flu vaccinations over the past year. As the pandemic continues and new variants of COVID-19 take root, organizations are unable to project what future vaccine administration will look like**. Many providers have needed to pay higher-than-expected payments for external staffing agencies and overtime pay due to the staffing shortages. In addition, some organizations have seen the cost of administering preventative vaccines increase due to the need to equip staff with the proper PPE needed to treat patients.**

<u>Payment for COVID-19 Vaccine Administration in the Home</u>
Last year, CMS announced a new add-on payment with a national rate of $35.50 when a COVID-19 vaccine is administered in the beneficiary's home. Providers and suppliers administering a COVID-19 vaccine in the home will be paid a national average payment $75.50 dollars per dose ($40 for COVID-19 vaccine administration and $35.50 for the additional payment for administration in the home, and both payments are geographically adjusted). The agency has asked for comment on what should count as "home" for the current $35 add-on payment for certain vulnerable beneficiaries who receive the COVID-19 vaccine at home.

In response to the ongoing PHE, many organizations have had to implement new modes of care such as mobile vaccine administration in response to the COVID-19 pandemic. As describes in the section above, these organizations have also had to implement additional preventive measures to address the risk to staff for COVID-19 transmission, most notably spending additional funds on PPE. **Due to this increased expense, we suggest that CMS classify mobile vaccination as "home" so that these organizations qualify for payment that would help to mitigate the financial investment they've made to ensure they are able to safely vaccinate patients.**

## 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, Executive 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