AMERICA'S PHYSICIAN GROUPS

September 6, 2022

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; CY2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements [CMS-1770-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 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [and] Medicare Shared Savings Program Requirements. APG supports the agency's continued efforts to improve both traditional Medicare and the Medicare Shared Savings Program (MSSP) and offers specific recommendations and suggestions to ensure these programs' movement from volume to value.

About America's Physician Groups

APG is a national professional association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models. APG's motto, "Taking Responsibility for America's Health," underscores APG's member

organizations' preference for being in risk-based, accountable, and responsible relationships, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for APG's groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage their populations of patients in more constructive ways than if they were merely compensated for the units of service that they provide. APG's member groups collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians). These professionals in turn provide care for nearly 45 million patients.

Below is a summary of APG's comments, followed by a more detailed presentation of these comments and recommendations to the agency.

I. **Summary of APG's Comments**

Medicare Shared Savings Program

- Use of the Area Deprivation Index (ADI) to determine which beneficiaries live in areas with high levels of socioeconomic deprivation raises concerns for APG and its members. CMS should continue to refine and test use of the ADI, including comparing alternatives and potentially designing a blend of the ADI with other indices, in this context before settling on one definitive process for determining advance-investment payments (AIPs).
- CMS should expand the types of ACOs eligible to receive AIPs so that those entering the *enhanced* track and those with specific health equity initiatives can also obtain AIPs.
- APG has concerns about the glide path proposed in smoothing the transition to performance-based risk. If the proposal is finalized as is, APG recommends that the agency implement a method to track progress in achieving health equity goals, so that the benefits of having a glide path are made clearer.
- If CMS implements the proposal to update the historical benchmark by incorporating a prospective, external growth rate factor, the revised policy should also remove ACOs' beneficiaries from the regional comparison population; allow ACOs the flexibility to choose one of two benchmark approaches that works best for them; and allow ACOs to adopt the revised policy as soon as they are ready to do so.
- APG supports adjusting ACO benchmarks to account for prior savings.
- APG supports reducing the impact of the negative regional adjustment and also recommends that the agency move regionally efficient ACOs to fully regional benchmarks over time (e.g., by the second agreement period).
- APG recommends that, in calculating county fee-for-service (FFS) expenditures to reflect the differences in prospective assignment and preliminary prospective assignment, CMS explore options for mitigating potential negative impacts. These options could include using a phased-in approach; making the change optional for participants; or capping the negative adjustment.
- Although APG generally supports refinements to the risk adjustment methodology that are designed to better account for complex, high-cost beneficiaries, the organization also recommends removing dually-eligible beneficiaries from this calculation and

limiting it to non-duals, while including patients with end-stage renal disease (ESRD) in the calculation.

- APG supports expanding opportunities for low-revenue ACOs to share in savings.
- APG asks CMS to consider an alternative benchmarking proposal in the form of a statewide benchmark.
- APG supports the establishment of a sliding scale for determining shared savings and losses.
- APG supports extension of the eCQM/MIPS CQM incentive but encourages the agency to continue the web Interface beyond the two additional years to give ACOs sufficient time to implement a new reporting method.
- APG believes that the framework of the proposal for a health equity adjustment for high performers in the quality category is insufficient and recommends again that CMS continue to refine and test the use of the ADI in this context.

Updates to the Quality Payment Program

- APG remains concerned about the expiration of the 5 percent lump sum APM Incentive Payment and the negative effect it will have on attracting and incentivizing participants in the acceptance of downside risk. CMS should continue to explore options for maintaining this essential incentive if it is not renewed by the U.S. Congress.
- CMS should begin the process of measuring organizations' performance on health disparities by collecting data on a standardized basis as the industry determines which interventions are effective.

Telehealth and Other Services Involving Communications Technology

- APG supports CMS' codification of the 151-day extension on telehealth flexibilities and encourages the agency to continue to work with Congress on finding permanent solutions, particularly for audio-only telehealth.
- APG asks that CMS reconsider the implementation of its in-person visit requirement for telehealth mental services.
- APG recommends that CMS reconsider its proposal to cease the usage of modifier 95 after 152 days following the end of the public health emergency (PHE).

Evaluation and Management (E/M) Visits

- Although APG supports CMS' one-year delay of its split visits policy, it recommends that the agency reconsider implementation of the split visits policy entirely, even after the one-year delay.

Reducing Undue Administrative Burden and Other Policy Refinements

- APG supports the CMS proposal to reduce the frequency of annual standardized written notices from five times per agreement period to once per agreement period.

- APG asks that CMS reconsider its proposal to require follow-up beneficiary communication because this will add significantly more administrative burden and may only confuse beneficiaries who receive such requests.

Rebasing and Revising the Medicare Economic Index (MEI)

- APG recommends that CMS delay implementation of this proposal until it has complete data regarding the distributional impact of changing the weight of RVUs across different types of physicians, states, and other categories.

II. APG's Fuller Comments and Recommendations

Medicare Shared Savings Program

Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

To increase participation in the Shared Savings Program, CMS proposes Advance Investment Payments (AIP) for ACOs that are considered low revenue ACOs, are inexperienced in performance-based risk, are new to the program, or that serve underserved populations. Under the agency's proposal, these organizations could receive advance shared savings payments of $250,000 and eight quarterly payments based on beneficiaries, with a cap of 10,000 beneficiaries. The more dual-eligible beneficiaries or beneficiaries who live in areas with high deprivation (as measured by the area deprivation index, or ADI) that are assigned to an ACO, the higher the AIPs. Recipients would be required to use payments to improve their infrastructure, increase staffing, or provide accountable care for underserved beneficiaries. CMS would recoup AIPs from any shared savings earned by an ACO in its current agreement period, and if necessary, future agreement periods.

APG supports the agency's commitment to exploring incentives to increase participation in the Medicare Shared Savings Program but believes that changes are needed in the AIP proposal. Specifically, the use of the ADI to determine which beneficiaries live in areas with high deprivation is of concern for APG and its members.

Although many researchers in the field of the social determinants of health believe that the ADI is the best tool currently available to account for levels of neighborhood socioeconomic disadvantage, use of the ADI in the context proposed by CMS has not been appropriately evaluated and validated. Providers in both California and New York note that the ADI does not accurately depict levels of deprivation in areas within their states and regions. As an example, the Tenderloin district of San Francisco has a high overall ADI, despite the growing presence of luxury housing in the area, so that use of the ADI to "label" the neighborhood as socioeconomically disadvantaged will paradoxically capture high-income populations in the calculation.

APG thus recommends that CMS continue to refine and test use of the ADI for the purposes to which it proposes to apply it, along with alternative measures of assessing the status of Medicare beneficiaries in high deprivation areas, before settling on one definitive process for linking levels of payment and other interventions to low socioeconomic status. Relying on national percentiles of the ADI (and possibly other indices) to identify "underserved communities" is problematic. Some states will have very few underserved communities because of underlying differences in socioeconomic status across states and because the ADI is not adjusted for differences in cost of living between different geographic areas. Given the issues with ADI and national rankings, APG suggests that CMS consider alternatives, such as using an absolute measure like life expectancy, or modifying application of the ADI, such as blending the existing national ADI percentile with the state-level ADI deciles or a new state-level ADI percentile to recalibrate the ADI's contribution to the AIP score more locally and thus accurately. There may not be a single metric CMS can use to identify underserved communities in both rural and urban, high-cost and low-cost, and homogenous and heterogeneous areas, so it may be appropriate to use more than one tool or methodology to identify underserved areas.
APG also recommends that the agency consider expanding eligibility of ACOs to receive AIPs by allowing both ACOs entering the ENHANCED track, as well as existing ACOs with specific health equity initiatives, to receive these payments. Expanding eligibility to these ACOs would have the larger effect of increasing participation in the Shared Savings Program while also defraying expenses such as infrastructure costs associated with participating in health equity initiatives. By including ACOs participating in the ENHANCED track, the agency would extend assistance beyond ACOs that are on upside-only risk tracks and encourage organizations on the path to accepting downside risk to continue toward that goal. Savings for the Medicare program would be the likely result.

Smoothing the Transition to Performance-Based Risk

In another attempt to spur greater participation in the Shared Savings Program, CMS proposes limiting the ways in which ACOs inexperienced with performance-based risk can participate in a one-sided shared savings model. CMS proposes that these ACOs participate in one five-year agreement only by entering the BASIC track's glide path and remaining in Level A for all five years. These ACOs may then also be eligible for a second two-year agreement in a one-sided model under BASIC before transitioning to two-sided risk. For performance years beginning January 1, 2023, and in subsequent years, CMS's proposal would allow ACOs currently participating in Level A or B the option to elect to continue in their current level of the BASIC track glide path for the remainder of their agreement. For agreement periods beginning on January 1, 2024, and in subsequent years, the proposal would remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the ENHANCED track would be optional.

As noted above, APG supports the agency's commitment to exploring incentives to increase participation in the Medicare Shared Savings Program. **However, APG has serious reservations about this proposal due to the extended timeline it would create for ACOs taking on downside risk, and the effect on the viability and success of the Shared Savings Program and**

ACOs overall. The length of the glide path as currently proposed could potentially last as long as 12 years for participating ACOs. **APG has substantial concerns about the effect that such a long glide path could have on cost savings in the program.** Not requiring participating ACOs to pay funds back in the six-year track would constitute a no-lose situation for participants that would hurt the program's ability to accrue savings. **In addition, allowing ACOs this gradual a glide path could imperil improvements in the quality of care for patients.**

Delaying the acceptance of risk **could also have the downstream effect of causing additional movement into the Medicare Advantage (MA) program at the expense of the Shared Savings Program as Medicare beneficiaries and providers find the MA program to be more attractive than the Shared Savings Program due to effects of different payment and administrative features.** Although APG strongly supports MA, the organization believes that both MA and traditional Medicare should be robust programs so that they together benefit as many Medicare enrollees as possible.

It is laudable that CMS seeks to attract into MSSP smaller groups that may not have the ability or capital to commit to downside risk. However, should the agency finalize this proposal as currently constructed, CMS should ensure that such groups are committed to providing quality care at lower cost. APG **recommends that CMS at least implement some method of tracking progress in improving health equity to determine whether this objective is achieved when ACOs have a longer and easier glide path. Overall, CMS should ramp up oversight of ACOs that may participate in this type of agreement.**

<u>Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark</u>

CMS proposes new ways to update an ACO's historical benchmark for each performance year in the ACO's agreement period. Specifically, the agency proposes to incorporate into benchmark calculations a three-way blend of (1) a prospectively projected administrative growth factor, the Accountable Care Prospective Trend, or ACPT, along with (2) national and (3) regional growth rates. The three-way blend would be calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between benchmark year three and the performance year.

The ACPT would be projected by the CMS Office of the Actuary and would be a modification of the existing FFS USPCC growth trend projections used annually for establishing MA rates, excluding indirect medical education (IME) and disproportionate share hospital (DSH) payments. The ACPT growth factors would be set near the start of the agreement period for the ACO's entire five-year agreement period. The ACPT factors would remain unchanged throughout the ACO's agreement period.

The proposal would include a "guardrail" to provide protection for ACOs from larger shared losses (or potentially from the negative implications of financial monitoring) based on an updated benchmark computed using the proposed three-way blend as opposed to the current

national-regional blend. The guardrail would not apply to any shared savings calculation. CMS would also retain flexibility to reduce the impact the prospectively determined ACPT portion of the three-way blend may have if unforeseen circumstances occur during an ACO's agreement period.

APG generally supports this proposal to update the historical benchmark, which -it believes will assist in offsetting the "ratcheting" effect for ACOs participating in the program over multiple years. Setting the growth factor administratively may work better than continually rebasing the benchmark. For the specific implementation of any changes, however, APG has **concerns and additional recommendations.**

The ACPT is designed to mitigate the impact of the "rural glitch," which worsens the ratcheting effect on rural ACOs because they tend to care for greater portion of their region's total beneficiaries and thus see even more dramatic effects on the benchmark through lower regional costs. However, although the weighting factor proposed in the ACPT would be helpful, **the proposed ACPT methodology would not remove an ACOs' beneficiaries from the regional comparison population, which APG believes would address the rural glitch completely.**

Because the rural glitch effectively restricts the amount of savings that ACOs can accrue, APG **also recommends that** CMS run two benchmarks, one with historical regional weighting and one with the ACPT. The agency could then allow ACOs to choose which of the two approaches worked best for them.

Lastly, APG recommends that CMS consider allowing ACOs to adopt the revised policy as soon as they are ready to do so. This flexibility in timing would avoid a situation in which ACOs currently participating in the program would potentially have to wait several years to apply this new formula, while organizations newly entered into agreements would be able to begin immediately.

<u>Adjusting ACO Benchmarks to Account for Prior Savings</u>

CMS has proposed incorporating an adjustment for prior savings that would apply in establishing benchmarks for renewing ACOs and re-entering ACOs that were reconciled for one or more performance years in the three years preceding the start of their agreement period. This adjustment would return an ACO's benchmark to an amount that reflected its success in lowering growth in expenditures while meeting the program's quality performance standard in the performance years corresponding to the benchmark years for the ACO's new agreement period. CMS would adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment.

APG supports this proposal in full as it will assist the participating ACOs that have previously shared in savings.

<u>Reducing the Impact of the Negative Regional Adjustment</u>

CMS proposes to reduce the impact of the negative regional adjustment. Specifically, it proposes to decrease the cap on negative regional adjustments from -5percent to -1.5percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program for assignable beneficiaries in Base Year 3. After the cap is applied to the regional adjustment, the negative regional adjustment amount would be gradually decreased as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increased, or its weighted-average prospective HCC risk score increased. The proposal would employ a prior savings adjustment to offset negative regional adjustments for ACOs that had higher spending compared to their regional service area.

APG supports this proposal in general, with one slight change. The negative regional adjustment in many ways serves as a bigger impediment to participation in the Shared Savings Program than downside risk components because organizations entering the program may start their participation at a loss due to this adjustment. Modifying the adjustment further serves CMS' goal of encouraging increased participation in the program. However, APG **recommends this change: CMS should move regionally efficient ACOs to fully regional benchmarks over time (e.g., by the second agreement period).** CMS also should allow regionally inefficient ACOs to remain in historical benchmarks until they become efficient relative to their regions, then phase in the regional adjustment.

<u>Calculating County FFS Expenditures to Reflect Differences in Prospective Assignment and Preliminary Prospective Assignment with Retrospective Reconciliation</u>

CMS proposes to calculate risk-adjusted regional expenditures using county-level values computed using an assignment window that is consistent with an ACO's assignment methodology selection for the performance year. For ACOs selecting prospective assignment, the agency would use an assignable population of beneficiaries that is identified based on the offset assignment window. For ACOs selecting preliminary prospective assignment with retrospective reconciliation, it would continue to use an assignable population of beneficiaries that is identified based on the calendar-year-assignment window.

This proposal would mostly affect ACOs that participate in higher risk tracks as these are the organizations that prospectively assign beneficiaries. As a result, these ACOs could see a negative impact of between 2-4 percent on their revenues. **APG recommends that CMS explore other options for mitigating this potentially negative impact, such as employing a phased-in approach, making the change optional for participants, or capping the negative adjustment.**

<u>Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High Cost Beneficiaries and Guard Against Coding Initiatives</u>

CMS has moved to improve risk adjustment methodology in benchmarking to better account for medically complex, high-cost beneficiaries and guard against upcoding or overcoding by

modifying the existing 3 percent cap on positive prospective Hierarchical Condition Category (HCC) risk score growth. The agency proposes to subject an ACO's aggregate prospective HCC risk score to a cap equal to the ACO's aggregate growth in demographic risk scores between benchmark year 3 and the performance year plus 3 percentage points. CMS would calculate a single aggregate value for the cap equal to the dollar-weighted average growth in demographic risk scores across the four enrollment types plus 3 percentage points. The agency would only apply this cap to prospective HCC risk score growth for a particular enrollment type if the aggregate growth in prospective HCC risk scores, calculated as the dollar-weighted average growth in prospective HCC risk scores across the four enrollment types, exceeds the value of the cap.

APG generally supports the move to improve the risk adjustment methodology so that complex, high-cost beneficiaries are better accounted for. As noted in the proposed rule, the existing policy may disadvantage ACOs that serve more vulnerable populations or beneficiaries with complex medical needs. The proposal as written offers an improvement over the status quo.

However, **APG has two additional recommendations that the organization believes would improve CMS' proposal further**. First, **removing dually eligible beneficiaries from this calculation and limiting it to non-duals could be more appropriate.** The care required for dual eligibles is much greater than even this improvement to risk adjustment methodology is able to capture. The risk of the implementation of a cap resulting in some ACOs avoiding providing care for dual eligibles would result in those needing care the most not receiving it. Second, **adding ESRD patients in this calculation would also allow accounting for high-cost beneficiaries more accurately**.

Increased Opportunities for Low Revenue ACOs to Share in Savings

CMS has proposed the creation of additional opportunities for low revenue ACOs to share in savings. The agency proposes to expand the eligibility criteria to qualify for shared savings for agreement periods beginning on January 1, 2024, and in subsequent years, by enabling certain low revenue ACOs participating in the BASIC track to share in savings even if the ACO does not meet the minimum savings rate (MSR) requirement.

Eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate would receive half of the maximum sharing rate for their level of participation. For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted according to proposed sliding scale approach for determining shared savings.

APG supports this proposal. The MSR harms low revenue ACOs, and this revision would encourage new participants in the Shared Savings Program while assisting participants new to value-based care in gaining experience. However, **APG recommends that the agency explore**

ways to ensure that the low revenue standard is not gamed in such a manner that some ACOs qualify only through technicalities and are able to take undue advantage of any final policy.

Alternative Options for Addressing Concerns About the Effect of an ACO's Assigned Beneficiaries on Regional FFS Expenditures in Establishing, Adjusting, Updating, and Resetting the ACO's Historical Benchmark

CMS is seeking comment on alternative benchmarking policies, including (1) using an ACO's own assigned beneficiaries from the assignable beneficiary population in regional expenditure calculations; (2) expanding the definition of the ACO regional service area to use a larger geographic area to determine regional FFS expenditures; and (3) combining both proposals.

Many ACOs are harmed in the benchmarking process due to their organization's large footprint. **One idea that APG and its member organizations have considered for improving benchmarking is the creation of a statewide benchmark.** Establishing a benchmark on a statewide basis would force less efficient ACOs to improve. It would also serve to force regression to the mean by applying larger geographies to the benchmark.

Quality Performance Standard and Reporting

CMS proposes moving toward a sliding scale for determining shared savings and losses in performance year 2023. Beginning on January 1, 2023, and continued in subsequent years, the proposal changes the all-or-nothing approach to determining an ACO's eligibility for shared savings based on quality performance. Instead, there would be a scaling of shared savings rates for ACOs that fall below the 30th/40th percentile quality standard threshold required to share in savings at the maximum sharing rate, but that meet minimum quality reporting and performance requirements.

An ACO's quality score for a performance year and the determination of whether the ACO met the Shared Savings Program quality performance standard would affect the determination of shared savings for that performance year and, for ACOs participating in the ENHANCED track, the amount of any shared losses owed. Beginning in performance year 2023 and for subsequent performance years, if an ACO failed to meet the existing criteria under the quality performance standard to qualify for the maximum sharing rate, but the ACO achieved a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set, then the ACO would share in savings (if otherwise eligible) at a lower rate that reflected the ACO's quality performance category score.

APG supports this proposal strongly. The all-payer requirement that is currently in place is an inappropriate standard that should be removed. The removal of the cliff as proposed by CMS will help in allowing participating ACOs to potentially share in savings.

Extension of eCQM/MIPS CQM Incentive

CMS has extended the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunsetting of the CMS web interface reporting option and to allow ACOs an additional year to gauge their performance on the eCQM/MIPS CQMs before full reporting of the measures are required beginning in PY2025.

APG continues to support this extension as it has in previous comment letters, due to the required investments for ACOs transitioning to comply with eCQM standards. APG c**ontends that continuing the web interface option beyond the two additional years will give ACOs sufficient time to implement a new reporting method**. APG appreciates the movement toward electronic quality measures, which reduce reporting burden. However, it continues to be technically difficult to operationalize due to interoperability issues among different EHRs. Thus, APG recommends that CMS further delay eCQM reporting until vendor implementation of interoperability is completed.

Health Equity Adjustment for ACOs that Report All-payer eCQMs/MIPS CQMs, and are High Performing on Quality, and Serve a High Proportion of Underserved Beneficiaries

CMS has proposed a health equity adjustment on quality scores of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs. The adjustment is based on (1) high quality-measure performance and (2) provision of care for a higher proportion of underserved or dually eligible beneficiaries. It uses the ADI score and Medicare and Medicaid dually eligible status to assess underserved populations, which would allow capturing of broader neighborhood level and individual beneficiary characteristics. This adjustment would add bonus points to the ACO's MIPS quality performance category score if the ACO scores in the top third or middle third of performance for each quality measure.

Although APG agrees with CMS's conclusion that those ACOs that perform highly on quality and serve underserved beneficiaries should be recognized for the care they provide, **the framework established in this proposal is insufficient**. Assessing quality on all-payer reporting but only measuring this on Medicare patients is insufficient. The proposal as currently constituted also fails to create any real incentives for treating this population.

As noted above in APG's comments regarding the creation of AIPs, **adoption of the ADI concerns APG as use of the ADI in this context has not yet been fully proven and validated.** As such, **APG recommends that CMS continue to refine and test ADI along with alternative measures of beneficiaries in high deprivation areas, before settling on one definitive process**. As also noted above, APG recommends **that the agency consider developing a blend of a national and a state ADI to encourage efforts in all states.**

Updates to the Quality Payment Program

Request for Information on Quality Payment Program Incentives beginning in Performance Year 2023

CMS submitted a request for information on how stakeholders would like CMS to respond to the transition from the 5 percent lump sum Advanced Alternative Payment Model (AAPM) Incentive Payment awarded to Qualifying APM Participants (QPs) in payment years 2019-2024 to the 0.75 percent Conversion Factor update available in payment years 2026 onward.

APG members continue to be concerned about the expiration of the 5 percent lump sum AAPM Incentive Payment and the continued negative effect that the absence of the incentive payment would have on attracting participants to accept downside risk. Should this incentive payment be allowed to expire, the incentives surrounding participation in MIPS will be higher than those for advanced APMs.

Given CMS's goal to have all beneficiaries in the traditional Medicare program be in relationships with accountable care entities by 2030, the loss of this incentive would be devastating to its efforts. Although the best course of action to rectify this problem would be federal legislation to extend the bonus, **the agency should continue to explore what is within its power to adapt if there is no such legislation.**

Screening for Social Drivers of Health Proposed Measure

CMS submitted a request for information on the development and implementation of health equity measures for the quality performance category.

The issue of addressing health disparities constitutes a new frontier of work for most healthcare organizations and will require new methods of measurement for all organizations, including ACOs. Considerable financial and resource investment must also be made underserved and underrepresented communities. Because of the time needed to properly implement and account for this work, **APG suggests that CMS begin with measuring organizations on health disparities by collecting a standardized dataset of characteristics until the industry determines which interventions to reduce these disparities are effective**.

Telehealth and Other Services Involving Communications Technology

Implementation of Telehealth Provisions of the Consolidated Appropriations Acts, 2021 and 2022 (CAA)

CMS has codified the extension of several telehealth flexibilities that were extended for 151 days after the end of the Public Health Emergency (PHE) under the Consolidated Appropriations Acts of 2021 and 2022. These include the waiving of geographic and site-of-service requirements, coverage for audio-only services, allowing additional Medicare provider types to furnish such services, and waiving in-person initial visit requirements for mental health services. Following this period, audio-only telehealth services would be removed from the list of allowed services.

With one exception, APG generally supports this action from CMS. However, APG asks that CMS conduct further review of the effects of eliminating coverage for audio-only services on beneficiaries who may lack affordable internet and/or cellular access – a reality that may continue for some time beyond the public health emergency (PHE).

CMS' support for audio-only telehealth services during the PHE has clearly enabled better access to care, especially for beneficiaries in the same underserved communities that CMS is prioritizing (and particularly for those who lack access to adequate connectivity and/or technology to support a live video visit). Some studies have shown that up to 25 percent of seniors lack access to high-speed internet or smartphones. During the COVID-19 pandemic, providers have reported that many of their patients ages 65 and older 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 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. Reverting audio-only telehealth to pre-PHE bundled treatment would be a disservice to the most underserved Medicare beneficiaries, and **APG urges CMS to do all that it can, including working with Congress on supporting legislation, to enable permanent support for audio-only telehealth.**

CMS recognizes the need for such statutory changes over the long term to embed various telehealth flexibilities in law, but in the meantime, **APG encourages the agency to continue to do all that it can from a regulatory perspective to encourage use of telehealth services – particularly for** patients in rural areas, and other Medicare beneficiaries for whom telehealth has made care more easily accessible.

With respect to mental health care and telehealth, federal law has permanently expanded coverage for telehealth services for the purpose of diagnosis, evaluation, or treatment of mental health disorders after the end of the COVID-19 public health emergency. The Consolidated Appropriations Act of 2022 delayed for 151 days after the end of the PHE a requirement that beneficiaries have an in-person, non-telehealth service within six months of their first telehealth mental health service. APG believes that this requirement erects unnecessary barriers to care for many older adult patients, and in an area of care that already faces substantial challenges. APG urges CMS to provide regulatory flexibility and suspend this requirement until further statutory changes are enacted.

In particular, APG recommends that CMS consider the contractual agreements that many health care organizations have in place with outside behavioral health groups that are not at the same TIN level. Policy language pertaining to an in-person, non-telehealth visit prior to the mental telehealth visit that would be being furnished by a different practitioner in the same

specialty/subspecialty in the same group should be written more flexibly to account for those organizations that work with outside behavioral health groups.

Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19

CMS proposes having telehealth claims require the appropriate place-of-service (POS) indicator to be included on the claim, rather than modifier "95," after a period of 151 days following the end of the PHE. It also proposes that modifier "93" be used to indicate that a Medicare telehealth service was furnished via audio-only technology, where appropriate, beginning January 1, 2023. Telehealth services billed with POS 02 after the PHE ends will once again be paid at the MPFS facility rate, with exceptions for Medicare telehealth mental health services, clinical assessments for patients with ESRD who are receiving home dialysis, and Medicare telehealth mental health services that are co-occurring with substance use treatment that are furnished with the patient in their home. For these exceptions, POS 10 should be used by the billing practitioner.

APG asks that CMS reconsider this policy of reversing the usage of modifier 95 at 152 days following the end of the PHE. For providers who provide services that are currently billed using the fee schedule's facility rate versus the non-facility rate, the CMS proposal will result in up to a 30 percent decrease in payment once it is put into place. Many patients in rural and underserved areas, as well as older adult patients who may lack access to transportation are able to have consistent access to health services due to the expansion of telehealth. Reverting to the non-facility rate for telehealth services after the end of the PHE will have the effect of disincentivizing the use of telehealth services. A reduction in payments will both harm the future of improving access and quality of care and erase the progress that has already been made. The result would be that patients no longer receive care that they have been accustomed to receiving from their doctors via telehealth since March 2020.

Evaluation and Management (E/M) Visits

Split (or Shared) Visits

CMS proposes a delay of the policy it finalized in calendar year CY2020 for E/M visits furnished in a facility setting. The policy allows payment to a physician for a split (or shared) visit (including prolonged visits), in which a physician and NPP provide the service together (not necessarily concurrently) and the billing physician personally performs a substantive portion of the visit. For visits other than critical care visits furnished in CY 2022 and 2023, "substantive portion" would mean one of the three key components (history, exam, or mobile device management solutions) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

APG is pleased that the agency has decided to postpone the implementation of this policy for an additional year, since APG believes that it would constitute 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, patients may be seen by their Internal Medicine Primary Care physician and then subsequently need a pelvic examination that they prefer be done by a female Nurse Practitioner in the same group. This arrangement 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 received reimbursement, the non-value-added administrative time would be substantial.

For these reasons, APG also reiterates APG's earlier recommendation that CMS refrain from enacting this proposal, even after CY 2024. A better alternative could be for the physician to reference the other services provided in his/her documentation and then bill for cumulative care.

Reducing Undue Administrative Burden and Other Policy Refinements

Proposal to Modify Beneficiary Notification Requirements

APG supports CMS's proposal to reduce the frequency of annual standardized written notices from five times per agreement period to once per agreement period. Doing so would result in a reduction of administrative burden for healthcare organizations while providing increased transparency for beneficiaries.

Although **APG supports reducing the frequency of annual standardized notices, it asks that CMS reconsider its proposal to require follow-up beneficiary communication**. This proposal will add significantly more administrative burden than is currently required and may only confuse beneficiaries who receive such requests. Taking away clinicians and care management staff from diagnosing and treating beneficiaries and instead having them dedicate time toward tracking verbal follow up conversations among a patient and provider, office staff, or care management staff, and doing so across multiple practices and multiple electronic health records, would not be a good use of ACO resources or time.

Rebasing and Revising the Medicare Economic Index (MEI)

CMS proposes to rebase and revise the cost share weights of the Medicare Economic Index (MEI), which measures the input price pressures of providing physician services, for CY 2023. CMS solicits comments on the proposal, as well as on the potential use of the proposed updated MEI cost share weights to calibrate payment rates and update the Geographic Practice Cost Index (GPCI) under the Physician Fee Schedule (PFS) in the future.

CMS contends that the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in furnishing physicians' services, particularly with respect to

physician ownership practices, rather than only reflecting costs for self-employed physicians. The agency's proposal would employ new methodology for estimating base year expenses that relies on publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. The proposed methodology would allow for the MEI to be updated on a more regular basis. Using the new MEI cost weights to set PFS rates would not change overall spending on PFS services but would result in significant changes to relative payments among PFS services. CMS is not proposing to use the proposed updated MEI cost share weights to set PFS payment rates for CY 2023.

While APG members recognize that MEI input prices have shifted since the agency last undertook a rebasing and revising effort, APG's members believe that the agency does not currently possess data that will sufficiently allow it to undertake the rebasing and revising of the MEI. The CMS proposal would increase the weight of practice expense and decrease the weight of work in the calculation of MEI. Because these changes would be budget neutral, they would create winners and losers among different types of physicians (e.g., raising relative payment rates for radiation oncologists while decreasing relative payment rates for family physicians). Payments would also be redistributed across states and other categories in ways that are not yet fully understood. **APG recommends that CMS delay implementation of this proposal until it has the proper data to do so.** Additional research and analysis are needed to accurately measure the costs that physician practices incur. The American Medical Association has indicated plans to study the effects of the proposed change within different types of physician practices. Once the results of the AMA study are available, the agency will be able to implement a more informed MEI rebasing and revising policy.

Conclusion

APG thanks CMS for considering the above comments and recommendations. It is important that CMS continues to work with stakeholders to strengthen Medicare and incentivize the move toward value. APG looks forward to a final rule that accomplishes these goals.

Please feel free to contact Jennifer Podulka, Vice President of Federal Policy (jpodulka@apg.org) or Matt DoBias, Vice President of Congressional Affairs, (mdobias@apg.org) if you have questions or if APG can provide any assistance as you consider these issues.

Sincerely,

Susan Dentzer
President and CEO
America's Physician Groups