September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

SUBJECT: CMS-1751-P. Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements; Proposed Rule, August 23, 2021

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule proposed rule for calendar year (CY) 2022.

HAP is pleased to see the agency's continued efforts to retain important telehealth flexibilities permitted during the COVID-19 pandemic but concerned with the proposals made impacting payment for office/outpatient evaluation and management (E/M) visits.

The following comment letter also addresses:

- Appropriate Use Criteria
- Opioid Use Disorder Treatment Services
- Changes to quality programs

We have also taken the opportunity to include reference to the very important work Pennsylvania hospitals are undertaking with respect to health equity.

In addition, we incorporate, by reference, all of the comments provided in the American Hospital Association's response to the proposed rule.

Thank you for your consideration of HAP's comments regarding this proposed rule. If you have any questions, contact Kate Slatt, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,

Jeffrey Bechtel
Senior Vice President, Health Economics and Policy

Attachment

Leading for Better Health

HAP Comments—Physician Fee Schedule
Proposed Rule for Calendar Year 2022

Payment for Evaluation and Management Visits

In this rule, the Centers for Medicare & Medicaid Services' (CMS) continues its efforts to refine the current Evaluation and Management (E/M) payment system and is proposing changes to the following:

- "Split" or shared E/M visits
- Critical Care Services
- Teaching Physician Services

"Split" E/M Visits: Split visits occur when both a physician and a non-physician provider (NPP) provide services during an E/M visit. In this rule, CMS proposes to define "substantive portion" as more than half of the total time spent by the physician or the NPP. CMS further proposes that the distinct time of services spent by each physician or NPP furnishing a split visit would be summed to determine total time of the visit. This would establish who provided the substantive portion of the visit and would therefore bill for the service.

If a physician performs a substantive portion of the visit, they can bill for the E/M and receive Medicare payment equal to 80 percent of the otherwise applicable payment of the Physician Fee Schedule, which is the lesser of the actual charge or the fee schedule amount for the service. If the NPP performs a substantive portion of the visit and therefore bills for the service, payment is 80 percent of the lesser of the actual charge or 85 percent of the fee schedule rate.

Critical Care Services: CMS is proposing several changes related to critical care visits including:

- Adopting the prefatory language of the Current Procedural Terminology Professional Codebook that defines critical care and delineates where, when, and by whom critical care may be delivered
- Define concurrent care as more than one physician or qualified NPP furnishing services to the same patient on the same day
- Allow critical care services to be furnished as concurrent care if medically necessary and not duplicative
- No other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty and same group
- Bundle critical care visits with procedure codes that have a global surgical period

Teaching Physician Services: As part of its changes to E/M visit coding last year, CMS permitted the use of medical decision-making (MDM) or time spent to select and bill for appropriate E/M visits. In this rule, CMS is proposing that when total time is used, only the time that the teaching physician is present may be considered.

CMS also proposes a change to the "primary care exception," which allows for payment in some teaching hospital primary care centers for certain lower complexity services when performed by a resident without the presence of a teaching physicians. CMS proposes to only allow MDM in determining the appropriate E/M visit rather than also allowing time in these circumstances.

There are significant consequences related to the proposals governing payment for certain E/M services as outlined above. The current proposal related to split billing does not take into account how clinical workflows are structured. This proposal also directly contradicts former efforts to reduce administrative burden and will cause significant patient flow inefficiencies at a time when the strain on the health care workforce has never been greater, and the need for patient care has never been more urgent in the wake of COVID-19.

HAP urges CMS to resist finalizing the split visit proposal in which "substantive portion" is based on time. As has been the practice, medical decision-making should determine the appropriate level of E/M visit.

HAP also urges CMS to withdraw its proposals related to critical care visits including the bundling of critical care visits with procedure codes that have a global surgical period until further evaluation can be conducted on unintended consequences.

Telehealth

Category 3 Services: As a result of the COVID-19 pandemic, CMS added multiple services to the Medicare telehealth list for the duration of the emergency. CMS is proposing to make some of these additions permanent.

Prior to CY 2021, Medicare had two criteria categories for assessing requests for adding or deleting services from the Medicare telehealth list of services under Section 1834(m) of the Social Security Act:

- Category 1 are services similar to other services already on the Medicare telehealth list
- Category 2 are services that are not similar and, therefore, require additional supporting evidence of clinical benefit

In the CY 2021 final rule, CMS created a new category. Category 3 describes services added during the Public Health Emergency (PHE) for which there is clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence to consider the service as permanent additions under Category 1 or 2 criteria. Category 3 services are to remain on the telehealth list until the end of the PHE.

Undoubtedly, the COVID-19 pandemic has created a world of uncertainty for patients and their health care providers. CMS recognizes this uncertainty and the impact the end of the PHE might have on Category 3 services and proposing to retain all Category 3 services until the end of CY 2023.

Geographic Limitations: The Consolidated Appropriations Act of 2021 (CAA) waived the long-standing geographic limitations placed on the provision of telehealth services and also added the patient's home as an originating site for purposes of diagnosis, evaluation, or treatment of a mental health disorder. In this rule, CMS is proposing that providers conduct in-person services within six months prior to providing an initial mental health telehealth service, and at least once every six months thereafter. This is specifically for mental health telehealth services made possible by the CAA—patients receiving mental health services in their homes and those patients in geographic locations beyond those currently authorized for Medicare telehealth services.

Audio-Only Telehealth Services: CMS also acknowledges the importance that allowing for audio-only mental health telehealth services have had during the PHE. In this rule, CMS proposes to amend the definition of "interactive telecommunications system" to include audio-only communication when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home. However, CMS is limiting payment for these audio-only services to providers with the capability to furnish two-way, audio/video telehealth services but are not doing so due to beneficiary technology limitations or preferences.

Direct Supervision: In the CY 2021 Physician Fee Schedule Rule, CMS finalized its proposal to extend the allowance for physicians and NNPs to provide direct supervision via audio/video technology through the end of the calendar year in which the emergency ends or December 31, 2021, whichever is later. CMS is seeking comment about whether it should temporarily continue beyond the timeline above or be made permanent.

While a grim reality, the PHE has been the impetus for advancing access to health care through technology tenfold. Beneficiaries have been able to continue to see their health care provider and do so safely from the comfort of their own homes and will continue to demand access to telehealth. The Pennsylvania hospital community is eager to continue working with policymakers at the federal and state level to leverage the experiences of the pandemic and preserve expanded access to care through telehealth, when clinically appropriate.

HAP appreciates the significant actions that CMS is taking in this proposed rule, especially:

- Retaining Category 3 services through the end of CY 2023 regardless of the end of the PHE
- Making audio-only mental health telehealth services permanent

HAP urges CMS to make broad, permanent adoption of any services that were acceptable during the pandemic, given that only services that did not pose significant patient safety concerns were added to the list during this time. As such, we strongly support retaining Category 3 services through the end of CY 2023 and further suggest maintaining Category 3 as a permanent category. HAP also strongly supports making audio-only mental health telehealth services permanent as it has

become such a critical way to provide access and deliver these important services to beneficiaries.

While we strongly support the broadened originating site definition for coverage for mental health telehealth services, we also recommend additional analysis related to the requirement for in-person visits within six months of a telehealth service. This may be a barrier in treating Medicare beneficiaries who have become quite comfortable and satisfied in receiving their mental health services using telehealth capabilities.

HAP urges CMS to permanently allow direct supervision via audio/video technology.

Finally, while we appreciate the importance that telehealth has had in caring for patients with mental health needs and appreciate the attention CMS has given to these services, HAP urges CMS to make similar flexibilities available to non-mental health services.

Appropriate Use Criteria Program

CMS has been in the process of implementing the Appropriate Use Criteria (AUC) program for advanced diagnostic imaging during the past several years. During 2020, CMS began the educational and operations testing period. While testing, CMS continued to pay claims whether or not they correctly included AUC information. Testing was extended through 2021 as a result of the PHE.

Payment penalties were slated to begin January 1, 2022, however in consideration of the ongoing PHE, CMS is proposing to delay this phase until January 1, 2023, or the first of the January that follows the end of the PHE.

HAP fully supports the delay of the penalty phase of the AUC program and appreciates CMS' acknowledgement of the ongoing challenges the PHE has created.

Opioid Use Disorder Treatment Services

As a result of the PHE, CMS issued an interim final rule on April 6, 2020, that allowed opioid treatment programs (OTP) to furnish counseling and therapy services using audio-only telephone calls for the duration of the PHE. In this rule, CMS is proposing to allow for continued audio-only telephone services in cases where audio/visual technology is not available to the beneficiary—defined as circumstances where beneficiaries are not capable or have not consented to the use of devices that permit a two-way, audio/visual interaction.

CMS will require the addition of modifier 95 and a new modifier that will indicate the provider had the capability of providing audio and visual services but used audio instead after the

conclusion of the PHE. These requirements will begin January 1, 2022, or at the conclusion of the PHE if that is after January 1, 2022.

HAP strongly supports CMS' proposal to allow for continued audio-only telephone services at the conclusion of the PHE as it has become such a critical way to provide access and deliver these important services to beneficiaries.

Changes to Quality Programs

The CY 2020 rule introduced the general framework for future Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP) that CMS believes would align and reduce reporting requirements across the four MIPS performance categories and intended to include specific MVPs in the CY 2021 rule. Due to the PHE, CMS delayed the introduction of MVPs until at least CY 2022, but emphasized its commitment to the intended phase- in of MVPs over time.

In this rule, CMS proposes implementing seven optional MVPs beginning with the CY 2023 performance period. Specifically, the MVPs include:

- Rheumatology
- Stroke care and prevention
- Heart disease
- Chronic disease management
- Lower extremity joint repair
- Emergency medicine
- Anesthesia

The rule also proposes additions to MVP development criteria, MVP eligibility and registration process, reporting requirements, and scoring approach for MVP participants.

HAP supports the consideration that CMS has given to the impact of the PHE in implementing the MVPs and appreciates the voluntary nature of the implementation, however, HAP urges CMS to refrain from setting a date to begin implementation until it addresses several issues including but not limited to:

- ***Including applicable measures for the wide range of specialty types participating in the MIPS***
- ***Ensuring fair and equitable scoring across clinician, group types, and specialties***
- ***Ensuring minimal administrative burden for multi-specialty group practices***

CMS is continuing its efforts to refine the MIPS an incentive program for eligible clinicians that results in positive or negative payment adjustments of up to 9 percent during CY 2023 based on CY 2021 performance.

Specifically, CMS proposes the following:

- Quality Category: CMS proposes to lower the weight of the quality category 30 percent during CY 2022 to reach the statutorily mandate

- Cost Category: CMS proposes to increase the weight of the cost category to 30 percent during CY 2022 to reach the statutorily mandate

- Improvement Activities Category: CMS proposes to include a new improvement activity, "create and implement an anti-racism plan," modify five existing improvement activities to focus on health equity, and update the complex patient bonus formula to include a social complexity component

- MIPS Final Score Thresholds: CMS proposes to double the complex patient bonus to a maximum of ten points for the CY 2021 reporting period

HAP continues to have significant concerns with proposals related to the cost performance category including increasing the weight of the category.

HAP urges CMS to produce detailed feedback containing actionable data related to the measures included in the cost category. HAP also urges CMS to refrain from increasing the weight of the cost category until existing concerns with methodology related to current cost measures are fully addressed and the impact of the PHE can be fully understood.

HAP strongly supports CMS' efforts to include activities promoting health equity and anti-racism in the MIPS program. Pennsylvania hospitals are committed and engaged in efforts to close health equity gaps. Including this in the quality program allows for further focus and engagement in these critical activities.

HAP supports doubling the complex patient bonus in consideration of the significant effort hospitals have been making in navigating the management of these patients during a PHE.

HAP continues to urge CMS to ensure that appropriate risk adjustments based on clinical complexity and sociodemographic factors are incorporated in all aspects of the MIPS.

Medicare Shared Savings Program

In response to comments made regarding last year's Medicare Shared Savings Program (MSSP) proposals specifically related to reporting electronic clinical quality measure/MIPS clinical quality measure (eCQM/MIPS CQM) all-payor quality measure under the Alternative Payment Model (APM) performance pathway (APP), CMS is proposing a longer transition by extending the

availability of the CMS Web Interface collection type for two years through CY 2023 performance year.

The rule also notes that, for CY 2022 performance year, accountable care organizations (ACO) would be permitted to report either the current MSSP measure set via the CMS web interface, or the MISP APP measure set. During CY 2023, ACOs that chose the Web Interface measure set also would be required to report at least one measure from the APP measure set. Additionally, CMS is proposing a freeze of one year to the minimum quality performance standard from 30 to 40 percentile. The new minimum would be effective during CY 2024 rather than CY 2023.

HAP supports CMS' efforts to create a longer transition for reporting eCQM/MIPS CQM by maintaining the availability of the CMS Web Interface collection option but ask that CMS remove the requirement for the reporting of one measure from the APP measure set during CY 2023.

HAP also supports the delay of increasing the minimum quality performance standard for one year.

Health Equity Request For Information

CMS recently has used the Inpatient Prospective Payment System rulemaking process to expand the role of quality measurement to identify inequities. In this rule, CMS is requesting additional information relating to its work to advance health equity.

While there have long been clear signs of disparate health outcomes, this issue became glaringly apparent during our nation's efforts to combat the COVID-19 PHE. This has created a "call to action" and Pennsylvania's hospitals are responding.

HAP has been working collaboratively with members and the Pennsylvania Department of Human Services to introduce a new hospital quality incentive program aimed at addressing health inequities and racial disparities. Initially, the program will focus on implementing pathways that incentivize:

- Creating and implementing a structured race, ethnicity, and language (REaL) data collection process
- Using REaL data to identify gaps and address inequities
- Screening and identifying social needs and social risks
- Convening internal and external stakeholders to identify opportunities to close gaps

The expressed goal of the program is to improve disparate outcomes stratified by race related to preventable admissions.

In addition to working with the state to create programs for hospitals to begin to address this issue, HAP also is embarking on the launch of a new Racial Health Equity Learning Action Network that will bring Pennsylvania hospitals together to share best practices related to the meaningful work being done on health equity in this state.

Pennsylvania hospitals also have been actively participating across other initiatives as well, including:

American Hospital Association 123 Equity Pledge

During 2015, the American Hospital Association launched its #123forEquity pledge campaign, which built on the efforts of the National Call to Action to Eliminate Health Care Disparities. More than 1,650 hospitals, including 49 Pennsylvania hospitals and health systems, pledged to take action to eliminate health care disparities. In the pledge, member hospitals and chief executive officers committed to taking action to accelerate progress related to the four areas of the initiative's call to action:

- Increasing the collection and use of race, ethnicity, and language preference data
- Increasing cultural competency training
- Increasing diversity in governance and leadership
- Improving and strengthening community partnerships

Philadelphia Area Hospitals' Commitment to Anti-Racism

Thirteen of HAP's southeastern Pennsylvania hospitals and health systems recently announced a collective commitment to combat racism, inequality, and discrimination in all its forms. Stating that racism is a health care issue and explicitly acknowledging that systemic racism drives the socioeconomic factors that are barriers to health care access, cosigners committed to:

- Re-examining policies and procedures and making changes, with an equity lens, that promote equality, opportunity, and inclusion for all
- Improving access to primary and specialty care for people in underserved communities
- Building trust through community partnerships with the goal of addressing chronic conditions that impact communities of color
- Advocating for investments that create innovative solutions to improve access, and provide safe, high-quality health outcomes for all communities in Pennsylvania
- Hiring and promoting leaders of color and increasing diversity in governance
- Renewing and expanding each organization's commitment to providing anti-racism and implicit/unconscious bias training for all staff, volunteers, and physicians
- Bridging relations between law enforcement and community by offering events aimed at encouraging conversations, improving relations, and creating trust
- Increasing the collection and use of race, ethnicity, language preference, and other socio-demographic data

HAP supports CMS' efforts to improve health equity through its quality programs as one prong of a multi-prong strategy. While the delivery of health care is vitally important in health equity, significant thought and investment must also be made to evaluate and address broader community resources and needs.