The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

October 5, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

SUBJECT: CMS-1734-P. Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA–PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Proposed Rule, August 17, 2020

Dear Administrator Verma:

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) 2021.

HAP is pleased to see the agency's efforts to retain important telehealth and scope of practice flexibilities permitted during the COVID-19 pandemic but are concerned with the budget-neutrality imposed on payment rates for office/outpatient evaluation and management (E/M visits).

The following comment letter also addresses:

- Implementation of SUPPORT Act
- Changes to quality programs

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 2021

EVALUATION AND MANAGEMENT (E/M) VISITS

The calendar year (CY) 2019 Physician Fee Schedule (PFS) rule finalized—for CY 2021 and beyond—a consolidated payment rate for evaluation and management (E/M) office and outpatient visit levels 2 through 4, while maintaining the payment rate for level 5 E/M visits.

Responding to significant negative feedback on the policy, CMS reversed course in the CY 2020 rule again setting separate payment rates for all levels of E/M visits rather than using the blended payment rate.

Additionally, CMS finalized policies including:

- Selection of the appropriate E/M visit level should be based on either the level of MDM or the total level of time personally spent by the reporting practitioner on the day of the visit (including both face-to-face and non-face-to-face time). This means that history and physical as elements for code selection are eliminated
- Elimination of level 1 visits for new patients (99201)
- Replacement of the finalized add-on G-code for extended visits finalized last year with an add-on CPT code for prolonged visits that would only be reported when using time to select the appropriate level of service
- Separate payment for add-on codes for visits with inherent complexity for some primary care and specialist visits

Because of the significant changes finalized last year, the AMA RVS Update Committee (RUC) revalued the E/M code set and they were made effective January 1, 2021.

In the rule, CMS is proposing to revalue additional services that are closely tied to E/M visits such as:

- ESRD monthly capitation payments services
- Transitional care management services
- Maternity services
- Assessment and care planning for patients with cognitive impairment
- Initial preventive physical examination and initial and subsequent annual wellness visits
- Emergency department visits
- Therapy evaluations
- Behavior health care services

In order to maintain budget neutrality with these changes, CMS is proposing a significant decrease of almost 11 percent to the conversion factor.

The most pressing issue related to these proposals is the budget neutrality impact. HAP supports efforts to urge Congress to waive this requirement. In the event that this does not occur immediately, HAP recommends CMS phase in the impact of budget neutrality over multiple years. HAP also urges CMS to consider the degree of re-distribution among specialties that this proposal could create and to ensure that clinicians caring for the most complex patients are not unfairly penalized by this solution.

HAP supports the proposal to adopt the coding changes and relative value units for E/M services.

TELEHEALTH

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. CMS is also proposing to create an additional category of criteria for considering when to add services to the list. Currently, Medicare has two criteria categories:

- 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

The proposed category 3 would include services that have not been made permanent by CMS' proposal above but would allow them to remain on the list on a temporary basis. Category 3 services would remain on the list until the end of the calendar year in which the emergency declaration is ended. After which, any category 3 services would need to meet category 1 or 2 criteria for permanent addition. Examples of the services that are being proposed for category 3 include ED visits, nursing facilities discharge day management, and psychological and neuropsychological testing. Some of those that are not being proposed for category 3 include higher level ED visits, hospital, intensive care, emergency care and observation stay, and therapy services (including physical therapy (PT), occupational therapy (OT) and speech language therapy (SLP).

CMS proposes to continue to allow non-physician providers (NPPs) such as licensed clinical social workers, clinical psychologies, PTs, OTs, and SLPs to bill for online assessment and management visits on a permanent basis.

While during the pandemic, CMS allowed for payment for audio-only E/M visits, it believes that it is statutorily unable to make this requirement permanent. Alternatively, CMS is evaluating the creating of a new coding and payment that would be similar to a virtual check-in but for a longer duration of time and at a higher rate.

CMS also proposes 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 also seeking comment on permanently retaining the ability to furnish inpatient and nursing facility visits via telehealth.

Undoubtedly, the COVID-19 pandemic has created a world of uncertainty for patients and their health care providers. While a grim reality, the pandemic has also been the impetus for advancing access to health care through technology ten-fold. Beneficiaries have been able to continue to see their health care provider and do so safely in the comfort of their own home and will continue to demand access to telehealth when clinically appropriate.

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

- Making many of the services that were added to the Medicare telehealth list during the pandemic permanent
- Continuing to allow NNPs to bill for online assessment and management visits on a permanent basis
- Finding alternative means to code and pay for audio-only visits

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. HAP urges CMS to continue to be flexible in considering additional services as we continue in this public health emergency.

OPIOID USE DISORDER TREATMENT

Section 2005 of the SUPPORT Act, enacted in 2018, established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by opioid treatment programs (OTPs). Consistent with new statutory requirements, the CY 2020 final rule provided definitions payment methodologies and other details about the new opioid treatment programs (OTP).

In this rule, CMS proposes to implement two additional provisions from the SUPPORT Act as well as make refinements to the program.

CMS proposes adding payment for naloxone dispensing to the following list of defined services finalized for inclusion in the program last year:

- Opioid agonist and antagonist treatment medications approved by the Food and Drug Administration for use in the treatment of OUD
- Dispensing and administering such medications
- Substance abuse counseling
- Individual and group therapy

- Toxicology testing

Currently, naloxone is covered under Medicare Part D, however, CMS acknowledges that the Part B OTP benefit has no co-pay and adding it will increase access to this life saving drug. CMS is proposing to change the definition of OUD treatment services to include naloxone dispensing for emergency use and proposes to establish two new add-on codes to pay for the dispensing of a take-home supply of nasal naloxone and the take-home supply of auto-injector naloxone furnished by OTPs. The distribution of naloxone is limited to one every 30 days, as medically reasonable and necessary.

CMS proposes to allow providers to enroll in Medicare via either form 855A or 855B, which would allow OTPs to bill on either institutional or professional claims, whichever is their preference. They also provide flexibilities for those providers that are already enrolled using 855B to switch enrollment types without incurring an additional site visit.

As part of the SUPPORT Act implementation, the rule also proposes the inclusion of two additional elements for Initial Preventive Physical Examinations and Annual Wellness Visits. They include:

- Screening for potential substance use disorders
- Reviewing any current opioid prescriptions

HAP supports CMS efforts to ensure beneficiaries have access to necessary services to address OUD including adding naloxone distribution to the benefit for the OTC program and supports the proposal to enable OTCs to easily enroll as they wish for billing purposes. HAP urges CMS to continue efforts to investigate more comprehensive payment models that would address a wider range of substance use disorders and focus on long-term recovery.

CARE MANAGEMENT AND REMOTE PHYSIOLOGIC MONITORING SERVICES

CMS has determined that there is relatively low utilization of transitional care management (TCM) services even though studies show it to be highly effective for beneficiaries' transition to community settings. In the proposed rule, CMS attributes this to two factors:

- Administrative burden in the billing process (restriction of healthcare common procedure coding system (HCPCS) codes that can be billed during the three-day TCM service period)
- Payment rates

To alleviate these issues, CMS is proposing to allow an additional 15 previously restricted HCPCS codes to be billed concurrently with TCM in addition to the 16 HCPCS codes that were finalized last year.

In addition to addressing TCM, CMS is proposing a new code to capture shorter time increments related to its Psychiatric Collaborative Care Model (CoCM). The CoCM integrated behavioral health and primary care by promoting care management and regular psychiatric inter-specialty consultation.

HAP supports CMS efforts to reduce the burden associated with providing and billing for care management. Providing care to complex patients with chronic conditions requires significant time and coordination of services. This proposal would permit clinicians to be paid for the important work that they are doing. HAP also appreciates CMS response to calls for a new code applicable to shorter duration care management services within the CoCM. HAP urges CMS to continue to evaluate opportunities to evaluate and improve payment as appropriate.

SCOPE OF PRACTICE

Several changes have been proposed to enable health care professionals to practice at the top of their licenses and to expand workforce capacity.

We support efforts that ensure that federal regulations not only reinforce current standards of practice, but also reduce barriers to care and promote improvements in the quality of care delivered by hospitals.

HAP's vision is "A Healthy Pennsylvania," and HAP's mission is to empower hospitals and health systems as the leading advocates for improving health in their communities. To be able to implement this vision, hospitals and health systems need to have a strong workforce that is able to provide care to their full practice authority in all patient care settings.

HAP is strongly opposed to statutory and regulatory barriers that unduly prevent any health care practitioner from caring for patients fully within their statutorily defined scope of practice. Improving access to care by optimizing the skill set of health care practitioners is vital.

The changing nature of health care requires that all members of the health care team work together as part of an inter-professional team. In order to meet the growing health care needs in the commonwealth, every member of the health care team must be able to practice to the full extent of their education, training, and license.

HAP supports efforts to maintain the workforce flexibilities proposed in this rule.

CHANGES TO QUALITY PROGRAMS

CMS is continuing its efforts to refine the Merit-Based Incentive Payment System (MIPS), an incentive program for eligible clinicians that results in positive or negative payment adjustments of up to 9 percent in CY 2023 based on CY 2021 performance.

Specifically, CMS proposes the following:

- *Quality Category*: CMS proposes to lower the weight of the quality category to 45 percent in CYs 2021 and CY 2022, 40 percent in CY 2023, and 30 percent in CY 2022 to reach the statutorily mandate

- *Cost Category*: CMS proposes to increase the weight of the cost category to 15 percent in CYs 2021 and 2022, 20 percent in CY 2023, and 30 percent in CY 2022 to reach the statutorily mandate

- *MIPS Final Score Thresholds*: While previously finalizing the CY 2023 MIPS performance threshold (i.e., the minimum score to avoid negative payment adjustments) at 60, CMS is proposing to lower that to 50 as a result of the COVID-19 pandemic. The exceptional performance threshold (i.e., the minimum score to receive exceptional performance bonuses) will remain at the previously finalized 85 points for CY 2023

The CY 2020 rule introduced the general framework for future MIPS Value Pathways (MVPs) that CMS believes would align and reduce reporting requirements across the four MIPS performance categories and intended to include specific MVPs in this rule. Due to current COVID-19 pandemic, CMS is delaying the introduction of MVPs until at least CY 2022 but emphasizes its commitment to the intended phase in of MVPs over time.

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

HAP also 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. HAP also urges CMS to consider the impacts of COVID-19 when finalizing any proposal.

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.

Finally, HAP appreciates CMS delaying the introduction of specific MVPs until at least CY 2022 due to the COVID-19 pandemic and urges CMS to provide sufficient definition and detail around this proposal including obtaining stakeholder feedback.

CMS is also proposing changes to the Advanced Alternative Payment Models (APMs). Specifically, CMS proposes establishing a targeted review request process for APMs, similar to that in the MIPS program beginning with the CY 2021 performance year. The targeted review allows beneficiaries and groups to review errors in how CMS has calculated performance.

CMS is also proposing an alternative methodology for calculating qualifying participant (QP) threshold scores which would allow additional providers to meet the threshold.

HAP supports efforts to allow clinicians to identify potential clerical error in CMS calculations and believes this will enhance transparency of the program. HAP also supports any efforts made by CMS to encourage participation in APMs including adjusting the QP threshold. HAP also encourages CMS to support efforts to urge Congress to extend the 5 percent bonus beyond 2024.

This year's rule proposes significant changes to the Medicare Shared Savings Program's (MSSP) including:

- Reducing the number of measures in the ACO measure set from 23 measures to six (same measures used in the new MIPS APP)
- Removing the requirement for ACOs to report quality data using the CMS web interface and implement requirements that data submission be done via the methods available to groups under the MIPS
- Increasing the quality performance standard required to be met in order to share in savings from 30th percentile to 40th percentile and compare ACOs to all other MIPS participants—essentially requiring ACOs to be at the 40th percentile or above across all MIPS quality performance category scores
- Utilizing ACO's quality performance scores to scale savings and losses (i.e., shared losses could be less if an ACO has a high quality score)
- Terminating ACO participation agreements for those that fail to meet the minimum quality score for two consecutive performance periods

The rule also proposes changes to the MSSP Extreme and Uncontrollable Circumstances Policy for CY 2020 and beyond including:

- Waiving the requirement to field the CAHPS survey due to COVID-19 pandemic for CY 2020
- Making quality measure data reporting optional for CY 2020
- Setting the quality performance scores at the 40th percentile of the MIPS quality performance scores for affected ACOs in CY 2021
- Considering an alternative policy for CY 2022 and beyond by adjusting the amount of shared savings for ACOs that either report data but fail to meet the minimum quality standard or are unable to complete quality reporting

While HAP supports some aspects of the proposed changes like reducing the number of quality metrics and scaling the losses for ACOs based on their quality performance, HAP urges caution as CMS continues to make significant changes to the MSSP program each year. Minor changes to program design can cause significant variances in performance in a program such as the MSSP. HAP suggests CMS seek further stakeholder feedback related to the new measure set prior to implementation.