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October 5, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) “CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1734-P].”

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing approximately 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, cost-effective, patient-centered medical care. Our overarching legislative and regulatory goals revolve around advancing the shift from fee-for-service (FFS) payments to reimbursement based on the value of care provided.

AMGA is pleased to offer these recommendations for your consideration.

Key Recommendations

Payment for Evaluation and Management (E/M) Services

- CMS should not finalize its proposal to increase the relative value units (RVUs) for the evaluation and management (E/M) codes due to the significant decrease in the conversion factor. This decrease, when combined with the effects of the novel coronavirus 2019 (COVID-19) pandemic, would create significant financial hardship for various specialties within AMGA member groups.

Additions to the Telehealth List

- AMGA believes that telehealth will be a core service moving forward and supports CMS' efforts to add additional codes to the Medicare telehealth list.
- AMGA supports the proposal to add a number of codes to the telehealth list on a Category 1 basis.
- While outside the scope of this proposed rule, AMGA recommends that CMS exercise all administrative authority at its disposal to waive the telehealth geographic and originating site requirements.

Continuation of Payment for Audio-Only Visits

- AMGA strongly recommends that CMS permanently add payment for audio-only services.

Medicare Shared Savings Program

- **APM Performance Pathway (APP):** While AMGA supports burden reduction and streamlining quality reporting for entities participating in value-based models, we are concerned about the extent to which CMS is reducing the Medicare Shared Savings Program (MSSP) quality measure set. CMS should not implement the APP as proposed and should work to implement a mix of outcomes and process measures that align across various programs. Additionally, AMGA does not support CMS' proposal to end the quality "phase-in" (eliminating the pay-for-reporting year) with the implementation of the APP.
- CMS should not apply the quality performance standard to shared savings the way it is proposed. ACOs should not be ineligible to share in savings if they do not meet the more stringent quality performance standard.

Quality Payment Program

- **APP:** AMGA supports the use of the APP as a scoring pathway for Merit-based Incentive Payment System (MIPS) alternative payment models (APMs), as long as CMS maintains its other reporting mechanisms in the process.
- **CMS Web Interface:** AMGA opposes the elimination of the CMS Web Interface, as doing so would impose undue burden on ACO participants.
- **Cost Performance Category:** AMGA recommends that there be more modeling on the impact of adding the costs associated with providing these telehealth services to the previously established cost measures.
- **Quality Measure Benchmarks:** AMGA supports CMS' intended approach of using performance period benchmarks for the calendar year (CY) 2021 performance period.

Payment for Evaluation and Management Services

CMS is proposing to implement a number of significant changes to the CPT descriptions, guidelines, and payment rates for office and outpatient E/M services.

CMS is proposing to implement a number of coding and documentation changes, along with an increase to the RVUs for office and outpatient E/M visits in 2021. AMGA appreciates that CMS is working to increase support for primary care services, a longstanding and widely supported goal. While AMGA supports the coding and documentation changes, we recommend that CMS not finalize its proposal to increase the RVUs for the E/M codes. The Physician Fee Schedule's (PFS') budget neutrality requirement, along with the continued effects of the COVID-19 pandemic, would cause significant hardships for AMGA members, many of whom suffered significant losses because of the pandemic.

Conversion Factor Decrease

Due to changes to the RVUs and the budget neutrality requirement, the proposed CY 2021 PFS conversion factor is \$32.26, a decrease of \$3.83 from the CY 2020 conversion factor of \$36.09. This is the most significant year-to-year change since 2010. From a high of almost \$38 in 2008, the proposed \$32.26 represents a significant decrease in support of Medicare FFS providers. In

addition, while not exceeding the downward adjustment maximum of 5 percentage points (as detailed at 42 CFR § 414.30), the decrease of \$3.83 is a marked change from previous adjustments.

CMS modeled the impact of these changes by specialty. For example, the agency expects payments to increase from 13% to 17% for endocrinology, family medicine, rheumatology, and hematology/oncology. Conversely, CMS expects payments to decrease 8% to 11% for surgeons, nurse anesthesiologists, chiropractors, and radiologists. AMGA supports an increase in support for primary care services, but not at the expense of other providers. This shifting of resources, rather than increasing payments, has the potential to undermine the group practice model, where providers across specialties work as a team. Shifting dollars from one specialty to another in such a system does not serve to support primary care, but rather creates difficulties for group practices, which will need to revise their physician compensation plans.

CMS also should recognize the larger financial situation facing physicians, group practices, and integrated systems of care. Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare payment rates will not include a statutory update. In addition, the MACRA incentives for Advanced APMs expire shortly, as the authorization for the 5% incentive ends in 2024. Also, the thresholds for Advanced APM participation increase, creating difficulties for providers to qualify. More important than any of the underlying regulatory changes, however, is the COVID-19 pandemic and its ongoing effect on patients' willingness or ability to seek care from their providers. For example, earlier this year, AMGA conducted a survey of its membership and found that 60% of independent medical groups expected to deplete their cash reserves within weeks, largely due to the elimination of non-essential surgeries and instructions to keep their patients at home. While our members are recovering financially from the lost revenues that resulted from the pandemic, they are still facing difficulties and uncertainties about a possible resurgence of the virus, as well as changes in patient behaviors. AMGA members are closely examining their financial situation, and it will take time for them to recover.

Effectively, AMGA members are facing headwinds on multiple fronts: a proposed significant decrease in the conversion factor, the expiration of the incentive payment for assuming risk in value-based models of care, and an ongoing public health emergency that has created significant financial distress. Now is not the time to add additional changes into the Medicare system.

CMS also should acknowledge the abbreviated timeframe that AMGA members will face should the agency implement the rule as proposed. While the agency addressed the increased payment rate for select E/M services in earlier rulemaking, a detailed estimate of the effect of the changes was not available until now. In fact, as part of its 2020 rulemaking cycle, CMS noted that it could not "estimate with any degree of certainty what the impact" of the changes to E/M services would be. At the time, given the various factors that influence the changes, including the Relative Value Scale Update Committee (RUC) process, it was understandable that CMS could only provide an illustrative example of the potential impact. However, AMGA mentioned in our comments on the CY 2020 Physician Fee Schedule proposed rule that it was "entirely possible that our members will not have an accurate estimate of the impact of this proposed rule until November 2020." Now, with the delay in the 2021 rulemaking cycle due to the COVID-19 pandemic, CMS does not expect to promulgate a final a rule until early December 2020. This further truncates the time that providers will have to prepare for any changes, which based on the now available estimates, stand to be significant. AMGA members will not have sufficient

time to prepare for the change in payment for E/M services.

Based on the significant decrease in the conversion factor, the ongoing disruption caused by the pandemic, and the looming expiration of support for the Advanced APM incentive program, AMGA recommends that CMS not move forward with its proposal.

Documentation and Coding

As finalized in the 2020 PFS final rule, CMS largely is aligning its E/M visit code and documentation policies in 2021 with changes recommended by the CPT Editorial Panel. Physicians will have the option of selecting the level of code using either total time or level of medical decision-making (MDM). CMS now is proposing to clarify the times for which prolonged office and outpatient E/M visits can be reported. CMS also is proposing to revise the times used for rate setting. AMGA endorses this change.

As noted in our comments last year, AMGA recommends that documentation requirements should provide only the necessary information to allow the primary provider and all other cross-covering providers to treat the patient longitudinally. Using time or MDM will help them dedicate their efforts to patient care and reduce the time spent on the administrative task of coding. However, AMGA also recognizes that using MDM to select an E/M code can be fairly subjective, and, therefore, we would reiterate that any review of claims that are based on MDM must recognize that CMS has instituted a policy that defers to the clinician judgement on selecting an appropriate code.

Additions to the Telehealth List

In response to the COVID-19 pandemic, CMS issued a number of waivers and regulations that increased the availability of telehealth, remote patient monitoring, and communications-based technology services. AMGA appreciates the steps CMS took to increase the regulatory flexibility surrounding telehealth. Looking beyond the pandemic, AMGA believes that patients will expect to maintain the ability to access care via telehealth and will view any regulatory barriers to such care as obsolete and counterproductive. Commissioners on the Medicare Payment Advisory Commission (MedPAC) acknowledged this new reality during their September meeting. For example, Commissioner Susan Thompson, M.S., B.S.N., interim president and chief executive officer of UnityPoint Health, said, "Telehealth is a core digital strategy for health care that, as a result of this pandemic, has become an expectation of our patients going forward."¹ AMGA supports removing the geographic and originating site requirements from the Medicare telehealth regulations.

CMS is proposing to add a number of services to the Medicare telehealth list on a Category 1 basis, meaning the services are similar to services on the telehealth list. CMS added these services to the telehealth list on a temporary basis as part of CMS' response to the public health emergency. AMGA supports this proposal.

CMS also is proposing to add a number of services to the telehealth list on a temporary basis because there is currently insufficient evidence to support their permanent inclusion. These services, which were added to the telehealth list in response to the COVID-19 pandemic, would remain on the list through the calendar year in which the COVID-19 public health emergency ends. AMGA supports the inclusion of these codes, but recommends that they remain on the list for at least an additional year after the conclusion of the public health emergency. This would

provide AMGA members with the necessary time needed to implement any changes should CMS remove the codes from the list.

CMS also is proposing changes for telehealth and nursing home care. Due to the public health emergency, CMS waived the requirement that visits for nursing home patients be conducted in person. AMGA recommends that CMS finalize its proposal to allow such visits via telehealth. In addition, under current policy, subsequent nursing facility care visits furnished via telehealth are limited to once every 30 days. AMGA supports the CMS' proposal to allow one telehealth visit every three days.

Continuation of Payment for Audio-Only Visits

CMS is seeking comment on the continuation of payment for audio-only visits. The agency is not planning to continue payment beyond the public health emergency for the codes that it established for audio-only telephone E/M visits in its March 31 interim final rule with comment period (IFC). However, CMS is seeking comment on whether it should develop a separate payment for telephone-only services and if it should remain in the PFS permanently. AMGA strongly recommends that CMS permanently add payment for audio-only services.

As we noted in our comments on the March 31 IFC, it has become clear that many patients do not have access to the devices or the broadband services necessary to receive care through video-based technology, such as a smartphone. For some patients, the choice is between an audio-only telephone call and no visit at all. Since then, our members have confirmed the importance of audio-only visit. A large number of patients simply do not have the means to access care if a video component is required.

To that end, CMS should continue separate payment for audio-only services. The RVUs for these audio-only codes should be comparable to telehealth and in-person services. In addition, AMGA recommends that these audio-only visits satisfy the face-to-face requirement for collecting diagnoses for risk-adjustment and care coordination purposes.

Medicare Shared Savings Program

AMGA and our members are strong supporters of the MSSP. Our members believe in CMS' flagship value-based model and carefully evaluate their participation and the necessary significant financial investments. As detailed below, AMGA is opposing a number of the proposals CMS has included in this proposed rule. In addition to objecting to the policy changes, AMGA members need stability in the program. On December 31, 2018, CMS published the "Pathways to Success" final rule, which included significant reforms to the MSSP and how our members may participate. Our members evaluated the program based on this regulation and many signed five-year contracts based how the program was going to be structured. Now, less than two years later, CMS is proposing additional changes. While our members expect technical updates to occur during the life of an MSSP contract, the modifications CMS is proposing in this rule go beyond that and represent significant changes to how participants will be evaluated for and earn shared savings. Our members are concerned that if finalized, they would participate in model that differs significantly from the one they agreed to.

APM Performance Pathway

CMS is proposing to revise the MSSP quality performance standard for performance year 2021 and subsequent performance years. Under this new proposal, MSSP accountable care

organizations (ACOs) would be required to report quality for purposes of the MSSP via the APP. CMS states that this new pathway would replace the current MSSP quality measure set. Additionally, ACOs would need to report only one set of quality metrics that would satisfy the reporting requirements under both MIPS and the MSSP.

While AMGA supports burden reduction and streamlining quality reporting for entities participating in value-based models, we are concerned about the extent to which CMS is reducing the MSSP quality measure set. The APP would score MSSP ACOs on six quality measures; ACOs would be required to actively report on three measures. We are especially concerned with the fact that two out of the six of these measures are utilization measures, which raises concerns about the lack of diversification in the measurement set. Further, reducing the number of measures by this drastic an amount could put too much emphasis on any one particular measure. For example, an ACO could perform well on five of the six measures but fail on one measure and their payments would be impacted disproportionately because they would be ineligible for any shared savings. This is particularly concerning, as the line between success and failure on a measure can be incredibly thin. For example, there is a less than 1% difference between the 30th percentile and the 90th percentile for the 2020 benchmark targets for ACO-8 “Risk standardized, all condition readmission.” With such a narrow window, factors outside the control of the ACO and its providers can prevent an otherwise successful ACO from earning shared savings. In addition, those high-performing ACOs that have successfully reduced admissions likely will have a subset of patients who are more likely to be admitted and subsequently readmitted due to their health status and condition, despite the best efforts of the ACO and its providers.

Our members also report that the burden associated with ACO quality measurement reporting is not due to the number of MSSP program measures, but rather the year-to-year changes that CMS requires of ACOs. AMGA members also must contend with the lack of alignment in measures from program to program (i.e., each program—MSSP, Medicare Advantage, traditional fee-for-service, and commercial contracts—has its own set of quality measures).

Therefore, AMGA opposes this change in the number of measures and encourages CMS to implement a better mix of outcomes and process measures that will align across these many programs and payers. Additionally, ACOs will report most of these measures (CAHPS and the utilization measures) without the ACO being able to review and verify their performance on these measures. ACOs need to be able to review and verify their quality performance to ensure that the results reported are accurate. For these reasons, we would urge CMS to seek more stakeholder input on the kinds of quality measures that are appropriate and properly capture the way ACOs deliver care before the agency attempts to implement such a major change within the program.

In proposing the APP, CMS states that “under this proposal, there would be no quality ‘phase in.’ All ACOs, regardless of performance year and agreement period, would be scored on all the measures in the APP for purposes of the Shared Savings Program quality performance standard.” AMGA strongly opposes this idea. The pay-for-reporting year is crucial for ACO providers to adjust to the new measures and benchmarks. The quality phase-in affords ACOs the time to acclimate to the program and learn how to deliver care in a value-based model. Additionally, ACOs use the experience gleaned from the pay-for-reporting year to implement care processes, workflow, and the health information technology changes needed to succeed in the model.

Removing the pay-for-reporting period would have a negative impact on new ACOs, especially with the new proposed quality performance standard that will apply to shared savings and shared losses. In this proposed rule, CMS is proposing revisions to the provisions establishing the final sharing rate for all ACO tracks, including proposing that if an ACO fails to meet the quality performance standard, the ACO would be ineligible to share in savings. We believe this would unfairly penalize new ACOs. In addition, removing the quality phase-in could discourage participation in the ACO program.

Shared Savings Program Quality Performance Standard

CMS proposes to change the quality performance standard from the 30th percentile on one measure in each domain to a requirement that ACOs achieve a quality score equivalent to the 40th percentile or above across all MIPS quality performance category scores. CMS believes that amending the quality performance standard will be in line with pushing ACOs to continue to improve their quality performance. AMGA does not support this change, particularly in light of how CMS proposes to apply the quality performance standard to the shared savings rate.

Use of ACO Quality Performance in Determining Shared Savings and Shared Losses

CMS also is proposing to revise the provisions establishing the final shared savings rate for ACOs in all tracks. Specifically, CMS proposes that if an ACO meets the quality performance standard, the ACO will share in savings at the maximum sharing rate. If an ACO fails to meet the quality performance standard, the ACO would be ineligible to share in savings. AMGA opposes these revisions, as ACOs already struggle to earn shared savings. CMS should not make the ability to share in savings an all-or-nothing proposition, particularly as CMS is proposing to increase the quality performance standards for ACOs.

Proposed Changes to the CAHPS for ACOs Reporting Requirements for Performance Year 2020

CMS is proposing to modify regulations to remove the requirement that ACOs field the CAHPS for ACOs survey for performance year 2020. Under this proposal, ACOs would automatically receive full points for each of the CAHPS survey measures within the patient/caregiver experience domain for the 2020 performance year. AMGA appreciates CMS waiving this requirement for ACOs due to the challenges administering the survey caused by the COVID-19 pandemic. Additionally, we recommend that CMS make all quality measures for performance year 2020 be pay-for-reporting. We contend that some measures will be difficult to satisfy if patients are not engaging with their providers in office or via telehealth, which is likely due to the current pandemic. Additionally, the restriction on elective procedures earlier this year may affect ACO performance, as patients could not see their providers for breast cancer, colon cancer, and various other screenings.

Quality Payment Program

APM Performance Pathway

CMS is proposing to use the APP as an optional MIPS reporting and scoring pathway for MIPS-eligible clinicians. AMGA supports the use of the APP as a scoring pathway, as long as CMS maintains its other reporting mechanisms.

Groups and Virtual Groups Reporting via the CMS Web Interface

Due to a decrease in participation over the years, CMS is proposing to sunset the CMS Web Interface measures as a collection type beginning in the 2021 performance period. Effectively, ACOs participating in the MSSP would no longer be able to utilize the CMS Web Interface for assessing and scoring ACOs. AMGA opposes the elimination of the CMS Web Interface, as doing so would impose undue burden on ACO participants. Many of the other reporting methods these entities could use for submission require electronic health record (EHR)-generated reports directly feeding into their systems. While theoretically an easy and ideal way to collect and report data, AMGA members report that not all patient information is collected via the EHR. The CMS Web Interface allows for more accurate reporting. Those ACOs that have become accustomed to this mode of data submission will suffer. Additionally, the amount of resources necessary to switch systems for these organizations will place an unnecessary cost and resource burden on ACOs.

AMGA recommends that CMS allow ACOs to continue to use the CMS Web Interface submission method in order to limit any disruptions for these entities. At a minimum, CMS should consider a gradual elimination of the CMS Web Interface and should allow ACOs to utilize it for another performance year.

Cost Performance Category

For the 2021 performance period, CMS is proposing to add the costs associated with telehealth services to the previously established cost measures. These codes currently are not included in the measures for a few reasons. First, some of these codes were newly included on the Medicare telehealth services list with the March 31 IFC and subsequent sub-regulatory processes established in the May 8 IFC. Secondly, some codes CMS proposes to add were not considered for inclusion because they were not billed widely enough to be found in empirical claims-based data. Wide use of telehealth services is novel for most providers. Many providers had to ramp up their use of telehealth due to the cancellation of non-emergent elective procedures and office visits caused by the COVID-19 pandemic. Because of this, AMGA recommends that there be more modeling on the impact of adding the costs associated with providing these telehealth services to the previously established cost measures. Providers need more experience with these services before the codes are factored into the cost performance measures.

Quality Measure Benchmarks

In this proposed rule, CMS is revisiting its benchmarking policy for the 2021 performance period due to changes in clinician data submission caused by the COVID-19 pandemic. CMS states that it intends to use performance period benchmarks for the 2021 performance period, meaning that benchmarks for calendar year (CY) 2021 would be based on actual data submitted during the CY 2021 performance period. CMS also suggests an alternative method that would utilize historic benchmarks from the 2020 MIPS performance period, which are based on submission for the CY 2018 MIPS performance period, for the CY 2021 performance period. While AMGA understands

CMS' rationale in choosing performance period benchmarks for the CY 2021 performance period, we contend that achieving quality performance is difficult when our member providers do not know what their quality targets are. Knowing that information ahead of time is useful for our members. However, we also contend that the alternative approach, using historic benchmarks, could be problematic since that data came from a non-COVID year; care will likely look different due to the pandemic and the benchmarks should reflect that difference. That said, AMGA supports CMS' intended approach of using performance period benchmarks for the CY 2021 performance period.

Low-Volume Threshold

For the MIPS 2021 performance period, CMS is not proposing any changes to the low-volume threshold criteria. As a result, those who bill \$90,000 or less in Part B-covered professional services, see 200 or fewer Part B patients, and provide 200 or fewer more covered professional services to Part B patients will be excluded from the program. However, those who meet at least one, but not all three, of the low-volume threshold criteria, may voluntarily opt into MIPS. CMS estimates that for performance year 2021, slightly more than 20,000 clinicians will opt into MIPS. The agency estimates that an additional 368,000 clinicians would be eligible to opt into the program but will not elect to do so. Overall, about 670,000 clinicians will be excluded from MIPS, compared to the estimated 931,000 who will participate in the program.

AMGA has long opposed the continuation of the low-volume threshold because of concerns that the number of clinicians excused from MIPS remains high. Excluding such a large number of clinicians who would otherwise be required to participate in MIPS will continue to have adverse consequences for both those who participate in the program and those who do not. Due to the budget-neutral nature of MIPS, eliminating a substantial percentage of MIPS participants collapses the range of positive and negative Composite Performance Scores, which in turn causes a substantial decline in the payment adjustments that providers will earn. For example, CMS estimates about 93% of clinicians will receive a neutral or positive payment adjustment for the 2020 performance period. Conversely, approximately 8% will receive a negative payment adjustment. Such a lopsided distribution of scores creates an unsustainable reimbursement system and undermines congressional intent for the program. Rather than provide a realistic and meaningful opportunity to earn a payment adjustment of up to 9%, as authorized by Congress, CMS estimates the maximum payment adjustment will be between 6.9% and 7.4%, and the aggregate adjustment will be 1.3%. This estimate is misleading, however, as all payment adjustments of more than a positive 1% are possible only through the exceptional performance bonus. As illustrated in Figure A on page 50319 of the *Federal Register*, those who earn a score higher than the performance threshold but below the exceptional performance score can expect a nominal update. CMS also notes it is possible that even more clinicians will score more than the performance threshold, which will further reduce the payment adjustments.

AMGA must reiterate our concern that such negligible payment adjustments do not reflect the considerable investments our members have made in transitioning to a payment mechanism that is based on the quality and cost of care provided. The low-volume threshold should be removed from the program. Not only would this improve the distribution of MIPS payment adjustments, it would provide meaningful incentives for all providers to move to value-based care. As AMGA has noted previously, the precursors to MIPS, the Physician Quality Reporting System program, the Meaningful Use incentive program, and the Value-Based Modifier program did not have an exemption for clinicians with a low volume of Medicare patients or allowed

charges.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director for regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA

¹ [Transcript](#), MePAC Public Meeting September 3-4, 2020.