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Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Brooks-LaSure:

On behalf of the AMGA, I want to express our appreciation for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') "CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1751-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.

AMGA is pleased to offer these recommendations for your consideration.

Key Recommendations

CY 2022 Rate Setting and Medicare Conversion Factor: CMS should not finalize its proposed decrease in the Medicare conversion factor and instead should exercise its authority to waive the budget neutrality requirements. If the conversion factor is left unaddressed, providers are facing significant cuts in Medicare reimbursements in 2022, creating an untenable situation for AMGA members and their patients.

Payment for Evaluation and Management (E/M) Services: AMGA is concerned that CMS' proposal for "split" E/M services undervalues physician expertise. In addition, the proposal would require practices to track time, effectively precluding physicians from using medical decision making to select the appropriate code.

Telehealth and Audio-Only Policy: CMS should continue payment for those services added to the telehealth list on an interim basis for at least one year beyond the end of the COVID-19 Public Health Emergency (PHE). In addition, CMS should maintain coverage and reimbursement parity for audio-only E/M codes beyond the end of the PHE.

Medicare Shared Savings Program: AMGA supports CMS proposal to extend the availability of

the CMS Web Interface and the proposed changes to the repayment mechanisms. AMGA also appreciates CMS' solicitation of comments on improving the regional benchmarks in the program, and we recommend that an accountable care organization's (ACO's) beneficiaries be removed when calculating regional costs.

Appropriate Use Criteria: AMGA supports the proposed delay in the Appropriate Use Criteria (AUC) program and recommends that CMS finalize this proposal. CMS also should exempt providers in value-based models of care from the AUC program.

Quality Payment Program: AMGA recommends that CMS not move forward with the Merit-based Incentive Payment System (MIPS) Value Pathway, which has the potential to add needless complexity into the program and undermine the team-based approach to care that is inherent in multispecialty group practices and integrated systems of care.

AMGA thanks CMS for the consideration of our comments, which are detailed below.

CY 2022 Rate Setting and Medicare Conversion Factor

CMS is proposing a conversion factor of \$33.58 for 2022, a decrease of 3.75% from the 2021 conversion factor. AMGA appreciates that the proposed conversion factor is a result of the 0% update scheduled for 2022 as required by Medicare Access and CHIP Reauthorization Act of 2022 and the expiration of the 3.75% payment adjustment that was included as part of the Consolidated Appropriations Act of 2021. The decrease in the conversion factor, along with changes in physician work, practice expense, and malpractice relative value units (RVUs) could have a significant effect on Medicare payments.

Providers are facing a confluence of potential payment cuts: The reduction of the conversion factor, the expiration of the moratorium on Medicare sequestration at the end of CY 2021, and the sequestration cuts mandated as part of Pay-As-You-Go rules that resulted from the enactment of the American Rescue Plan Act of 2021. As a result, providers are facing an upwards of 10% cut in the Medicare payments. This reduction comes as AMGA member organizations continue to face significant challenges from the COVID-19 pandemic and uncertainty on when the regulatory flexibilities provided as part of the PHE will expire.

AMGA appreciates that Congress will need to act to mitigate the effect of these potential cuts. However, CMS can use its authority under the PHE declaration to waive the budget neutrality adjustments that are driving the cuts in Medicare reimbursement. Under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure sufficient healthcare items and services are available to meet the needs of individuals enrolled in the programs during the emergency. AMGA recommends that CMS exercise its authority to waive the budget neutrality requirements and recalculate the Medicare conversion factor. Doing so would acknowledge the ongoing PHE and the continued strain COVID-19 is inflicting on the provider community.

Payment for Evaluation and Management (E/M) Services

CMS is proposing significant payment and coding changes to "split" or shared services for E/M services. CMS is proposing to allow shared services in a facility, with modifications to the requirements. CMS also is proposing to disallow using split services in physician offices, with the

justification that medical groups can use incident to services. Effectively, a medical practice billing under place of service 11 would not be allowed to use split visits, but those using place of service 19 or 21 could. Shared services would still be allowed in inpatient and emergency department settings.

Under the proposal, CMS would require that providers bill for such services under the name and National Provider Identifier (NPI) of the provider who spends the most time on the visit. If the physician spent most of the time on the visit, the physician would bill the visit. Conversely, if a non-physician practitioner (NPP) conducted the majority of the visit, the NPP would bill for the service. In addition, the billing provider would have to sign and date the medical record.

AMGA is concerned that this proposal creates a situation that devalues physician experience and treats all time as equivalent. As proposed, if a physician spent 14 minutes with a patient and an NPP spent 16 minutes, the entire 30 minutes will be billed as if the NPP conducted the entirety of the visit. As a result, a substantial portion of a physician's time may be uncompensated. AMGA is concerned that CMS is conflating experience and expertise with time. While a physician may, in some cases, spend less time as part of a visit, it is the physician's expertise and supervision that should be the determining factor for billing, not simply the number of minutes spent with a patient.

In recent rulemaking, CMS has worked to increase support for E/M services. Ironically, this proposed change may result in a decrease in reimbursement for E/M visits if the physician billing rate is not used because the NPP spent more time on the encounter. After finalizing changes in previous rulemaking as part of an update to the CPT E/M Guidelines, which were intended in part to reduce administrative burden, CMS' proposal to rely on time will require providers to track time on of the vast majority of E/M visits. This is particularly true in group practice settings, which inherently rely on a team-based approach to patient care. While CMS states that tracking time is not expected to be a new burden, AMGA contends this approach effectively precludes the use of medical decision making if a split visit is used.

AMGA also is opposed to the proposed requirement that the billing provider sign and date the medical record. This is a needless administrative requirement that will not support program integrity efforts.

CMS is proposing that a physician and NPP must be in the same group in order to bill a split visit. AMGA agrees with this proposal. However, CMS also is seeking comment on whether it should refine the definition of group for purposes of split billing. CMS did not propose any specific changes, but instead detailed options that are under consideration. For example, whether the physician and NPP should be in the same specialty or whether the definition should be aligned with the definition of "physician organization" as defined at Sec. 411.351, which addresses the physician self-referral law.

AMGA does not believe a further definition of group is needed. As CMS notes, a definition that is too restrictive may inadvertently prevent group practices, which may have multiple Taxpayer Identification Numbers (TINs), from billing split E/M services.

Telehealth and Audio-Only Policy

CMS is proposing a number of changes to its current telehealth policy. At the beginning of the pandemic, AMGA members altered the way they deliver care by eliminating elective surgeries and procedures and keeping patients away from their facilities. As a result, a significant expansion of telehealth services has occurred, allowing providers to reach patients in unprecedented ways. For example, our members reported an increase from 10 telehealth visits per month to an average of 2,000 telehealth visits per week. After more than a year of the pandemic, our members' patients have come to expect telehealth services as a standard of care delivered by their provider. AMGA's recommendations regarding CMS' telehealth policy and reimbursement are informed by our members' experience with technology during the pandemic and their patients' expectations on how they can access care. AMGA has several recommendations on CMS telehealth proposals.

Direct Supervision

As part of its response to the COVID-19 PHE, CMS is allowing providers to meet "direct supervision" requirements through real-time, interactive audio/video communications technology. CMS is seeking comment on the "possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time audio/video technology." AMGA recommends that CMS allow providers to meet "direct supervision" requirements via such technology on a permanent basis.

Temporary Additions to the Telehealth List

In response to the COVID-19 PHE, CMS added 135 services to the Medicare telehealth list on an interim basis. AMGA recommends that CMS keep these services on the Medicare telehealth list beyond the PHE. As noted in previous comments, 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. The ability to seek appropriate care via telehealth benefits patients who may be unwilling or unable to travel. It also provides clinicians with a window into their patients' day-to-day lives, providing invaluable intelligence into patients' living conditions and other factors that might not be visible in an office visit.

In its 2021 rule, CMS created a Category 3 for Medicare telehealth services. This category, which would remain temporary until the end of the calendar year in which the PHE ends, is intended to give CMS additional time to assess whether the services should remain available via telehealth. Now, CMS is proposing to extend the availability of Category 3 services through the end of 2023. AMGA supports this extension, with the caveat that the services should remain on the telehealth list for at least one year after the conclusion of the PHE. Ending coverage and reimbursement in the same calendar year as the end of the PHE would prove to be disruptive for both providers and patients. The additional year would provide AMGA members with the time needed to implement any changes should CMS remove the codes from the list.

Telephone (Audio-Only) Evaluation and Management Services

CMS is proposing to end reimbursement for a set of CPT codes for telephone, or audio-only, visits at the conclusion of the PHE. AMGA strongly objects to the proposal and recommends that CMS maintain coverage and reimbursement for these codes (99441-99443) beyond the PHE. In March 2020, CMS deftly responded to the need to expand access to care as quickly and as innovatively as possible. A large number of patients, particularly those who lack access to broadband internet, continue to rely on telephone service. As noted in our response to CMS'

March 2020 interim final rule with comment, 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. Recent research has indicated that telephone calls are the only form of telemedicine used by 1 in 10 Medicare beneficiaries.¹ A significant number of patients simply do not have the means to access care if a video component is required. To meet the needs of these patients, not only should CMS continue to include coverage of these codes, Medicare payment for the telephone E/M visits should continue to be equivalent to Medicare payment for office/outpatient visits with established patients.

Geographic and Originating Site for Mental Health Services

The Consolidated Appropriations Act of 2021 (CAA) authorized CMS to remove the geographic restrictions on the use of telehealth for the purpose of diagnosis, evaluation, or treatment of a mental health disorder. It also added a patient's home as the originating site for such care provided via telehealth. CMS is proposing to implement these new flexibilities in regulations, which AMGA strongly supports. CMS also will allow audio-only care if the patient is not capable of using, or does not consent to the use of, two-way, audio/video technology. While the provider must have video capabilities, CMS would permit audio-only if the patient cannot or will not use video. AMGA also supports providing the flexibility to meet patient needs by providing care through audio-only services.

CMS also is proposing to require an in-person visit six months before the first telehealth visit and six months after subsequent telehealth visits. AMGA is concerned that adding an in-person visit requirement would add additional administrative complexity into care management processes. AMGA is concerned that monitoring and tracking the timing of visits may prove to be administratively burdensome. Determining when an in-office visit is warranted should be left to the judgement of the patient's physician and care team. AMGA recommends that CMS finalize its proposal to eliminate the geographic restriction and add patients' home as a qualifying originating site for the telehealth treatment of mental health services. Given the lack of justification for mandating an in-person requirement, AMGA recommends that CMS defer to the judgement of the treating physician and care team on how frequently an in-person visit is warranted. The CAA provides CMS with the discretion to specify the intervals for in-person visits. If CMS is unable to eliminate the requirement entirely, it is important that any provider in the selected practice be able to conduct the in-person visit. AMGA is concerned that requiring a mental health provider to conduct the in-person visit may result in access issues, particularly in rural areas.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) directed CMS to develop an appropriate use criteria (AUC) and clinical decision-support mechanisms (CDSMs) for advanced diagnostic imaging services. CMS is proposing to delay implementation of the payment penalty phase of the AUC program to the later of Jan. 1, 2023, or the Jan. 1 that follows the end of the PHE. AMGA supports this delay and recommends that CMS finalize this proposal.

Beyond the short-term delay of the AUC that CMS is proposing, AMGA also recommends that CMS not move forward with the program, given Congress' interest in examining the current progress. As you are aware, the House-passed 2022 appropriations bill for the Department of Health and Human Services includes language requesting that CMS issue a report on the

“challenges and successes” of the AUC program. The report directs CMS to consider “quality improvement programs and relevant models authorized under Sec. 1115A of the Social Security Act and their influence on encouraging appropriate use of advanced diagnostic imaging.” Given the delays and Congress’ interest in evaluating the program, AMGA recommends that CMS delay the program and use its authority to eliminate it entirely for the providers in value-based care models, as the underlying rationale for the AUC program is not applicable in such models. Providers who have invested the time and resources in a value-based model of care have every incentive to provide the most appropriate care and avoid overutilization of services.

Medicare Shared Savings Program

AMGA and our members are strong supporters of the Medicare Shared Savings Program (MSSP), CMS’ flagship value-based model. CMS is proposing a number of changes to the MSSP. These include a continued phase-in of mandated use of electronic clinical quality measures (eCQMs), a proposal to aggregate quality data at the TIN level, and changes to the quality data completeness standard, among other changes.

Extension of the Web Interface

CMS is proposing to extend the CMS Web Interface as an alternative to reporting the three MIPS clinical quality measures (CQMs) through 2023 and seeks comment on extending it further. While AMGA appreciates that CMS is extending the availability of the Web Interface, CMS’ overall quality goal for the program is misplaced. Rather than attempt to overhaul a quality reporting mechanism that ACOs have successfully used for a decade, CMS instead should investigate how to improve data collection and reduce burdens. Changing the reporting mechanisms now will do little to further CMS’ quality goals, and instead will cause further stress for ACOs and group practices that are facing a number of critical situations, including a resurgence of COVID-19 cases, the financial ramifications from disruptions in their regular practice patterns, and staffing challenges.

AMGA agrees with the proposal to extend the CMS Web Interface and recommends that CMS extend it for longer than the proposed additional two years.

TIN Level Data Aggregation

CMS is proposing to allow ACOs to submit quality measures at the ACO participant TIN level. CMS then would aggregate the quality data to determine a score for an ACO. AMGA has several concerns with such a policy. For instance, aggregating data across multiple TINs will only result in an accurate score if the underlying data is valid. ACOs will be responsible for ensuring duplicated patient data is not submitted to CMS. However, as the files do not include a patient identifier, aggregated data likely will include duplicate patients, which raises questions on how ACOs can address this technical limitation. Moving forward with this proposal will result in inaccurate quality data.

MSSP Quality Performance Standard Thresholds

CMS is proposing to freeze the quality performance standard for ACOs at the 30th percentile across all MIPS quality performance category scores. In earlier rulemaking, CMS had proposed to increase the threshold to the 40th percentile. While the proposed rule would hold the quality performance threshold at the 30th percentile for performance year 2023, it would increase the threshold to the 40th percentile in performance year 2024. AMGA supports the proposal to freeze the threshold at the 30th percentile for 2023, but does not support the increase to the 40th

percentile for 2024. 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.” Given such a narrow difference, AMGA must reiterate our concern that factors outside the control of the ACO and its providers can prevent an otherwise successful ACO from earning shared savings. CMS estimates that during the 2019 performance year, about 20% of ACOs would have failed a performance standard set at the 40th percentile. However, in the proposed rule, CMS acknowledges there is “significant uncertainty” surrounding what the results would be in performance year 2023 under the higher standards. AMGA should freeze the threshold at the 30th percentile for both performance year 2023 and 2024.

CMS also is seeking comment on whether publicly displaying prior year performance scores would help to address the lack of advance information on the quality performance score ACOs must meet in order to satisfy the MSSP’s quality performance standard. AMGA recommends that CMS provide such information, which would help ACOs determine what standard they must obtain to meet the program’s quality requirements.

Accounting for Specialists in an ACO

CMS is requesting comment on evaluating specialty providers in an ACO. For example, CMS asks whether ACO participant TINs should be able to report through an applicable MIPS Value Pathway. As detailed elsewhere in this response, AMGA has concerns with the MIPS Value Pathway proposal. Adding such a mechanism into the ACO would undermine the concept of the MSSP, which evaluates providers—regardless of their specialty—as a single entity that is accountable for the cost and quality of care provided to a specific patient population. CMS should not move forward with any proposal that would segregate providers within an ACO for evaluation purposes.

Repayment Mechanism Amounts

CMS is proposing changes to the percentages used in calculating repayments amounts. Under current policy, the repayment mechanism is the lesser of either:

- 1% percent of the total per capita Medicare Parts A and B fee-for-service (FFS) expenditures for the ACOS’ assigned beneficiaries; or
- 2% of the total Medicare Parts A and B FFS revenue of its ACO participants.

CMS is proposing to reduce these amounts to 0.5% of the total per capita of the ACOs assigned beneficiaries and 1% of the total revenue. This effectively would cut in half the repayment mechanism amounts required for ACOs in shared risk models. AMGA recommends that CMS finalize this proposal.

CMS also is proposing to modify the threshold for determining whether an ACO is required to increase its repayment mechanism amount during its agreement period. ACOs must establish a repayment mechanism to assure CMS that they can repay losses for which they may be liable. Under current policy, an ACO may be required to adjust its repayment mechanism arrangement during its agreement period if the recalculated repayment mechanism amount exceeds the existing repayment mechanism amount by at least 50% or \$1 million, whichever is the lesser value. CMS is proposing to eliminate the 50% threshold. As a result, only ACOs with a recalculated repayment amount in excess of \$1 million would need to increase its repayment amount. AMGA agrees with the proposal, which would reduce administrative complexity for ACOs.

MSSP Beneficiary Assignment

CMS is proposing to revise the list of primary care services used to assign beneficiaries to ACOs. Specifically, CMS would add seven codes in PY 2022, including chronic care management, principal care management, and other E/M services. CMS also is proposing to maintain services temporarily added to the telehealth list on the ACO assignment list through the end of 2023. AMGA agrees with this proposal and recommends that CMS finalize it.

Comments on ACOs' Regional Benchmark

AMGA, a strong supporter of the MSSP, appreciates that CMS is requesting comments on improving how the program's benchmarks are established and updated. Currently, CMS includes all patients in a region in the calculation of fee-for-service expenditures. This approach effectively penalizes ACOs that are the most efficient providers in their market and makes it more difficult for them to earn shared savings. Removing the ACO population from the regional adjustment calculation ensures that the ACO is not competing against itself if it performs well relative to its market. AMGA believes this change will encourage ACOs to participate in the MSSP and reward them for performing well then they reduce costs and improve quality. CMS should remove ACO beneficiaries from the calculations when determining regional costs.

Quality Payment Program

Cancel the MIPS Value Pathways (MVP) Effort

In rulemaking last year, CMS delayed the implementation of the MIPS Value Pathways (MVPs) until the 2022 performance period. Now, CMS is proposing to start the MVP program on a voluntary basis in CY 2023. While AMGA largely supports the concept of measure alignment—one of the purported goals of the MVP option—the MVP proposal does not improve the underlying MIPS program or facilitate the transition to value. AMGA recommends that CMS forgo the MVP concept and instead focus on improving the traditional MIPS program, rather than sunsetting the program at the conclusion of the 2027 performance and data submission periods as proposed. Attempting to reform MIPS without addressing the underlying structural flaws, including the continued inclusion of a low-volume threshold, simply changes the administration of the program without improving the incentives for providers to invest in the infrastructure, staff, and culture change needed to deliver care in a value-based setting.

Beyond our overall objection to the MVP model, AMGA is concerned that building an MVP around a specific condition or clinical episode would undermine care coordination and contribute to the continued “siloeing” of care. In supporting documents, CMS states that MVPs “support patient-centered care, a continued emphasis on the importance of patient outcomes, population health, health equity, interoperability, and reduced reporting burden for clinicians.” The proposed MVPs indicate otherwise. In addition, AMGA is concerned that as CMS engaged in further MVP development, new MVPs will lend themselves to each particular specialty working to develop an MVP. This has the potential to undermine the care coordination that is the hallmark of the multispecialty medical groups and integrated systems of care and a necessary component of value-based care.

Given our objection to the MVP concept, AMGA recommends that CMS not require their use in 2028. If CMS remains committed to reforming MIPS by adding the MVPs, their use should be voluntary and physicians and group practices should retain the option to report in traditional

MIPS.

Should CMS move forward with the MVP concept, AMGA recommends that CMS develop an MVP built around the multispecialty group practice model. Rather than focus on a particular episode or condition, CMS could develop an MVP that is derived from the Group Practice Reporting Option.

CMS also is proposing to create a “subgroup” reporting mechanism for MVPs. These subgroups would be a subset of a group that includes one MIPS-eligible clinician and is identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician’s NPI. AMGA believes the subgroup concept undermines the overarching goals of the multispecialty group practice model. Creating subgroups within a group practice would potentially contribute to fragmented care. AMGA opposes the proposal to require multispecialty groups to form single-specialty subgroups in order to participate in MVPs starting in 2025.

MIPS Threshold

CMS is proposing to increase the threshold performance score from 15 points to 75 points, which represents the total MIPS score that must be earned to avoid a negative payment adjustment. CMS is basing this threshold by using the mean score from the 2017 performance year. AMGA agrees with this increased threshold.

Web-Based Interface

CMS is proposing to extend the CMS Web Interface as a collection type and submission type in traditional MIPS for registered groups, virtual groups, and Alternative Payment Model (APM) Entities with 25 or more clinicians for the 2022 performance year. AMGA supports this proposal.

Low-Volume Threshold

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. AMGA has long opposed the continuation of the low-volume threshold because of concerns that the number of clinicians excused from MIPS remains high. AMGA again must object to the continuation of this policy, which contributes to negligible payment adjustments. The low-volume threshold should be removed from the program.

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,



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

ⁱ [“3 Surprising Trends in Seniors’ Telemedicine use During the Pandemic,” Stat News, August 30, 2021.](#)