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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
ATTN: CMS-1734-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: [CMS-1734-P] Medicare Program: CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; et al.

Dear Administrator Verma:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to comment on the Physician Fee Schedule (“PFS”) Proposed Rule for Calendar Year (“CY”) 2021 (CMS-1734-P).¹ The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (“NPPs”) who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS and through the Quality Payment Program (“QPP”).

The AGS appreciates the continued engagement by the Centers for Medicare & Medicaid Services (“CMS”) with stakeholders on appropriate payment for evaluation and management (“E/M”) services. We strongly believe that Medicare must appropriately value these services which are at the core of high quality, person-centered care. However, we are concerned about the negative impact that changes to the office/outpatient E/M codes payment will have on payment for all services paid under the PFS. CMS proposes a reduction of 10.61 percent in the PFS conversion factor which will result in significantly lower payments to physicians, including many geriatricians, who primarily provide care in the patient’s residence and therefore do not use the office/outpatient codes. We urge CMS to take all possible steps

¹ 85 Fed. Reg. 50074 (Aug. 17, 2020).

to minimize this impact and to continue to work with specialty societies to ensure appropriate valuation of E/M services in all settings.

I. Recommendations

AGS recommends that CMS:

- Obtain input from the Relative Value Scale Update Committee (“RUC”) as the basis for revaluing codes that are analogous to the office/outpatient E/M codes;
- Adjust the work RVUs for the nursing facility, domiciliary, and home visit codes (99304 - 99318, 99324 - 99337, and 99341 - 99350) to maintain 2020 payment rates until those services can be revalued by the RUC;
- Allow the complexity add-on code (GPC1X) to be reported with E/M services furnished in the nursing facility, home and domiciliary care settings and further refine which practitioners can report GPC1X by use of the patient relationship codes;
- Assume utilization of GPC1X in 2021 of at most 23 percent of total expected utilization, consistent with experience with other new E/M codes;
- Continue to allow reporting of the prolonged service code (99XXX) if time exceeds the minimum required time for reporting 99205 and 99215 when using time as the basis of code selection, as finalized in rulemaking for 2020;
- Continue to allow reporting of the prolonged services without direct patient contact codes (99358/99359) when performed on a date other than the date of an office/outpatient E/M service;
- Add all of the services proposed as either Category 1 or Category 3 services to the telehealth list permanently as Category 1 services. If CMS chooses to finalize any codes as Category 3 services, then it should extend the period of time that Category 3 services will remain on the telehealth list, at least through the end of the calendar year following the year in which the PHE ends.
- Finalize as Category 1 services the home and domiciliary visit codes for established patients and the new patient codes for domiciliary care;
- Continue to cover audio-only services under the existing telephone E/M codes (99441-99443) until extended virtual check-in service codes can be developed and valued;
- Finalize the proposed establishment of new codes (G20X0 and G20X2) describing remote assessment of recorded video or images and a virtual check-in when furnished by a qualified healthcare professional who cannot otherwise report evaluation and management services;
- Allow clinicians to determine the appropriate frequency for provision via telehealth of subsequent visits to hospital or nursing facility inpatients;
- Make permanent certain flexibilities to supervise residents through real-time audio/video technology;
- Finalize the proposal to allow certain non-physician practitioners to supervise diagnostic tests as allowed by state law and scope of practice;
- Finalize the proposal to include the principal care management codes in the valuation for care management services furnished by rural health clinics (“RHCs”) and federally qualified health centers (“FQHCs”) (G0511);
- Clarify that the screening for potential substance use disorders (“SUDs”) and review of current opioid prescriptions being added to the Initial Preventive Physical Examination (“IPPE”) and

Annual Wellness Visits (“AWV”) do not include more comprehensive evaluation services should the screening indicate that the patient is at risk for a SUD;

- Finalize the proposal to allow separate reporting of additional services with Transitional Care Management services;
- Finalize the proposal to create a new code to report 30 minutes of psychiatric care collaboration management service;
- Finalize the proposed values for immunization administration codes and for the chronic care management service;
- Publish analysis of QPP data that assesses the impact of the program by physician specialty, practice setting, practice size, and clinician type;
- Not finalize the proposal to remove Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Measure # 048) as a quality measure from the MIPS program; and
- Finalize the proposal to increase the number of points available for the complex patient bonus to 10 points for the 2020 performance period/2022 MIPS payment year.

We discuss these recommendations in greater detail below.

II. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management Visits (section II. F.)

In the final rule updating PFS rates and policies for 2020, CMS finalized numerous changes in Medicare payment for office/outpatient E/M services to take effect January 1, 2021, including establishment of a new add-on code (*GPC1X Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*) to describe visit complexity.

CMS also asked for comment as to whether the changes in the E/M outpatient office visit codes should be reflected in the relative value units (RVUs) for other codes. Specifically, CMS asked whether the RVUs for services that require an E/M visit as part of the services should be revised to reflect the RVUs for the revised E/M codes and whether it would be necessary or beneficial to make adjustment to other services to maintain relativity between those services and the office E/M visits. **AGS urges CMS to consider the impact of the E/M changes on other outpatient E/M services not furnished in the office setting, especially services provided to beneficiaries in nursing facilities, at home or in residential settings such as assisted living and other domiciliary settings.**

In this rule, CMS proposes changes to some codes that contain office/outpatient E/M visits or that CMS believes are closely analogous to those services. Other codes, including the nursing facility, domiciliary and home visit codes, are not addressed.

A. CMS Should Obtain Input from the RUC Regarding Valuation of Analogous Codes.

We share CMS' concern that other services may need to be revalued, including the services for which CMS proposes changes for 2021, to assess relativity with the revised office/outpatient codes. However, we note that in this rule, CMS is proposing to use multiple methodologies to determine the new values including revising RVUs to reflect the marginal change in related office/outpatient E/M codes; maintaining the current relativity between a code and certain office/outpatient E/M codes; accepting RVU recommendations from an individual specialty society; and using the volume-weighted average change in the office/outpatient codes to adjust the RVUs for some codes. In addition to inconsistent methodologies, some of these services do not contain an office/outpatient visit. CMS, CPT and the RUC all agreed the office/outpatient services need to be redefined to better describe existing practice and then revalued. The same cannot be said of other analogous services unless they go through the same process. Except as noted below, we do not have a recommendation for the 2021 MPFS, so long as ultimately any services that are affected by adjustments go through the standard processes.

Most of the services CMS proposes to revalue are ones that would typically be referred to the RUC for review. Review and valuation by the RUC allows clinicians from different specialties to provide input on the resources needed to provide a service. **We urge CMS to use the RUC process to determine how codes should be revalued, rather than apply the multiple and varied approaches described in the proposed rule indefinitely. We urge CMS to continue working with the specialty societies, CPT and the RUC to ensure that all E/M services are appropriately described and valued.** However, CMS should use its general rate-setting authority to adjust the valuation of services that are not defined by CPT nor are typically reviewed by the RUC, such as the Annual Wellness Visit, in order to maintain appropriate relativity with the new office/outpatient values. **Additionally, we believe CMS needs to address the impact of the conversion factor reduction on select critical services furnished to the most vulnerable beneficiaries as these services go through the CPT and RUC processes.**

B. CMS Should Consider the Nursing Facility, Domiciliary, and Home Visit Codes to Be Analogous to the Office/Outpatient Codes and Adjust the Work RVUs to Avoid Reducing Payments for those Services.

CMS states in the rule “we believe that the magnitude of the changes to the values of the office/outpatient E/M visit codes and the associated redefinitions of the codes themselves are significant enough to warrant an assessment of the accuracy of the values of services containing, or closely analogous to, office/outpatient E/M visits.”² We are particularly concerned about the magnitude of the impact the proposed changes will have on E/M services furnished to patients in their residences which are reported under the nursing facility, domiciliary, and home visit codes which have not been revalued for many years. We are very concerned that these settings of care are already underserved and have become even more disadvantaged and these services are even more critically needed due to the PHE. Clinicians are seeking to minimize patient exposures and thus may more frequently need to make home or assisted living facility visits, particularly to avoid emergency room services whenever possible. The pandemic has created disproportionate mortality for those in nursing facilities and greater complexity for all who work there.

² 85 Fed. Reg. 50124.e

Services at home, the assisted living facility and nursing home reduce the burden on other care settings and are best for the vulnerable beneficiary.

Nursing home, domiciliary, and home visits have the same components as office visits and require similar levels of medical decision-making and therefore are closely analogous to the revalued codes. In particular, home and domiciliary services are the same as office/outpatient services in every way, except for the service location. They are relatively low volume services provided to a highly vulnerable population by professionals who are disproportionately affected by Medicare policy. The proposed reduction in the conversion factor will reduce the Medicare payment for those services by 8 to 10 percent depending on the specific service. CMS should evaluate its authority to take steps to maintain payment levels for these services in order to maintain access to care.

CMS could take one of two approaches. CMS could determine that the nursing facility, domiciliary, and home visit CPT codes are analogous to office/outpatient codes and adjust the work RVUs for those codes to take into consideration the changes in the values for the office/outpatient codes. We understand that the CPT Editorial Panel and RUC will be reviewing these codes in the near future so any increase in valuation by CMS would be temporary - likely for two years. Our primary concern is that beneficiaries continue to have access to these services in the near term and therefore we ask that CMS revise the work RVUs for 99304 - 99318, 99324 - 99337, and 99341-99350 to the extent necessary to maintain the payment rate for these codes at 2020 levels. Additional changes in value can wait until the RUC reviews these codes and sends its recommendations to CMS. Given the relatively small volume of services reported under these codes, we do not expect that this change would negatively impact the conversion factor. Our estimate of the RVUs required to achieve this outcome are shown below.

Table 1
Recommended Work RVUs to Maintain 2020 Payment Rates

Setting	Patient	HCPCS	Recommend Work RVU
Nursing Facility	Initial	99304	1.90
		99305	2.70
		99306	3.52
	Subsequent	99307	0.88
		99308	1.33
		99309	1.79
		99310	2.69
	Discharge Service	99315	1.48
		99316	2.19
	Annual nursing facility assessment	99318	1.96
Domiciliary	New	99324	1.18
		99325	1.75
		99326	2.99
		99327	3.95
		99328	4.70
	Established	99334	1.21
		99335	1.96
		99336	2.78
Home	New	99341	1.17
		99342	1.77
		99343	2.93
		99344	3.85
		99345	4.66
	Established	99347	1.14
		99348	1.79
		99349	2.64
		99350	3.74

Alternatively, for the home and domiciliary services, CMS could establish G codes that adopt the office/outpatient model of differentiating the level of service provided using medical decision making and total time on the date of the encounter. This code selection methodology is being proposed as the CPT/RUC E/M Workgroup extends the outpatient code changes to the codes describing care in

these two settings. While this approach would not provide the benefit of a full vetting by CPT and RUC, it would acknowledge that the services are inadequately defined and may permit CMS greater flexibility. CMS could set RVUs for the G codes that provides payment consistent with the 2020 payment rates for 99324 - 99337 and 99341 - 99350. The G codes would be deleted when the revised and revalued CPT codes are available.

C. CMS Should Allow Use of the Complexity Add-on Code with Nursing Facility, Home, and Domiciliary Visit Codes.

In the proposed rule, CMS states that the new complexity add-on code GPC1X is distinct from other preventive or care management codes because “GPC1X reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients’ health care needs with consistency and continuity over longer periods of time.”³ **The AGS agrees that such longitudinal relationships are critical elements of high quality care and urges CMS to clarify that the add-on code can be billed in all instances where this type of intense E/M service is furnished. In particular, CMS should clarify that the add-on code can be reported with outpatient visits furnished in settings other than the office, specifically nursing facility, home and domiciliary visits (99304 - 99318, 99324 - 99337, 99341 - 99345).** Domiciliary, home and nursing home visits are as complex as office visits and may be more complex because the physician is often acting as both a primary care physician and a specialist taking care of patients with acute illnesses superimposed on multiple chronic illnesses. Many geriatricians and geriatrics non physician professionals perform both office visits and home/domiciliary visits and believe they are identical with respect to building longitudinal relationships with patients and families. In many cases patients are seen at their residence on a regular basis because they are homebound and unable to go to a clinician office. This includes important transitional care services not reported with 99495 or 99496 which are essential to reducing hospital readmissions. Recognizing the visit complexity inherent to those services and allowing for reporting of GPC1X with home and domiciliary visit codes will help pay more appropriately for the care provided.

AGS also recommends that CMS consider better refining who can report the complexity add-on code. As described in the proposed rule, it appears that the code could be reported with most if not all office/outpatient E/M visits. We question whether such widespread use accurately captures genuine longitudinal care relationships. CMS has established patient relationship categories and codes and those codes specifically differentiate between practitioners who have a continuous relationship with the patient and those who are providing care on an episodic basis. CMS could better identify practitioners furnishing the complex, longitudinal care described by GPC1X by limiting its use to practitioners who are reporting the continuous care patient relationship codes.

D. CMS Should Assume Utilization of Complexity Add-on Code Will Be Not Greater Than 23 Percent of the Projected Use in the First Year the Code is Available.

It is not clear from the proposed rule discussion how frequently CMS assumes GPC1X will be reported in 2021. **AGS urges CMS to ensure that the assumption is consistent with experience of other**

³ 85 Fed. Reg. at 50,138.

codes in the first year of availability and does not overstate expected utilization. We note that, for most practices, the new code will not be included in billing software on January 1, 2021; it will be several months before the code can be easily included on electronic claims. This delay and the need to educate clinicians about proper use of the code mean that the utilization next year will likely be well below the use that could be anticipated three to four years after implementation. For example, utilization of transitional care management services (99495 and 99496) when first effective in 2013 was 24 percent and 22 percent respectively of the 2018 volume. Utilization of the chronic care management code (99490) in its first year (2015) was 23 percent of the 2018 volume.

We strongly encourage CMS to take this information into account when considering an appropriate utilization estimate. **AGS believes that no more than 23% of estimated claims would be the appropriate utilization estimate for the GPC1X add-on code.**

E. CMS Should Allow Reporting of the Prolonged Service Code (99XXX) When Time Exceeds the Floor of the Level 5 Time Range, As Finalized in Rulemaking for 2020.

In the 2020 final rule, CMS finalized recognition of CPT code 99XXX (*Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)*) beginning January 1, 2021. In the 2020 final rule, CMS stated that it interpreted the revised CPT prefatory language and reporting instructions to mean that CPT code 99XXX could be reported when the time for a level 5 office/outpatient E/M visit (the floor of the level 5 time range) is exceeded by 15 minutes or more on the date of service.

In the proposed rule, CMS states that it believes that allowing reporting of CPT code 99XXX after the minimum time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. Therefore, CMS is proposing that when the time of the reporting physician or NPP is used to select office/outpatient E/M visit level, CPT code 99XXX could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.

AGS disagrees with this understanding. In May 2020, the CPT Editorial Panel approved a clarification to convey that the original intent that time related to prolonged services began at the starting point of the code range. The RUC recommended values for 99205, 99215 and 99XXX consistent with that understanding of the guidelines and the tables on proper use of 99XXX were in the survey for that service. The medians and RUC recommended times to CMS for the purposes of valuation (and not coding) were 59 and 45 minutes respectively for 99205 and 99215. In other words, 99205 was slightly outside the descriptor range and 99215 was within the range at the lower end. This is not surprising and the 2020 typical intra-service CMS times and CPT descriptor typical face-to-face times do not match for 99205 and 99215. Under CMS' proposal to adopt the starting point for the counting of an additional 15 minutes at the upper bound of the descriptor range, for 99205, the starting point would be 89 minutes, a full 30 minutes beyond the survey time and the time for 99215 would be 24 minutes beyond the survey time. Additional units of 99XXX would be reported at 15 minutes, the survey time of this service.

The goal of CPT and stakeholders in establishing the new prolonged services code was to remove the current situation where 29 minutes of prolonged service is not recognized at all, but 30 minutes is recognized the same as 60 minutes. The CMS proposal results in 29 minutes not being recognized, but 30 minutes being recognized, although in this instance the 30 minutes is recognized as the same value as 15 minutes. We do not believe there is double counting in the case of the use of 99215 and 99XXX, even if the survey median total time on the date of the encounter was 45 minutes. We recommend that CMS implement the billing policy finalized in the 2020 final rule allowing reporting of 99XXX once the time range of the level 5 code is exceeded. We believe this should be done because this is how the services were described in CPT and valued by the RUC. It is also important to consider that the American Medical Association and specialty societies have been teaching about this proper use of 999XX since the publication of the final rule for 2020.

Though finalized in the 2020 final rule and only noted in the summary reference to 84 FR 62849 through 62850, we wish to state that we do not believe precluding 99358 and 99359 when associated with office/outpatient E/M visits is correct. These codes are not add-on services. They are services performed on a single date and cannot be reported on the same date of the related E/M. We do not believe it is burdensome or confusing to allow reporting in relationship to an office/outpatient E/M. They may be commonly performed outside of the windows of time used in the valuation of the office outpatient E/M codes. CMS proposes to finalize pre-service and immediate post service times for the office/outpatient E/M. In no case are those times greater than 15 minutes. Even if one assumes the total time of 15 minutes occurred on a single date and within the time window of either 3 days prior or 7 days after the date of service, this is well below the typical time of 99358, which is 60 minutes. As importantly, at least 30 minutes on a single date must be expended before 99358 can be reported. We do not believe the extensive review of records, images and other data, interprofessional care coordination and other services that are at the core of the use of 99358 are addressed by the pre or immediate post service times of 99205 or 99215. CMS should continue to allow reporting of the prolonged services without direct patient contact codes (99358/99359) when performed on a date other than the date of an office/outpatient E/M service.

III. Telehealth and Other Services Involving Communications Technology (Section II.D)

During the COVID19 PHE, CMS has allowed telehealth to be used in numerous instances when it would not otherwise have been available, including allowing broad geographic access to telehealth and allowing telehealth services to originate in the patient's home. In this rule, CMS emphasizes that requirements waived during the PHE, including geographic and originating site restrictions as well as restrictions on the types of practitioners who can furnish telehealth, will expire at the conclusion of the PHE. AGS believes that telehealth services will remain an important tool for ensuring Medicare beneficiaries have access to needed care well after the PHE ends. We continue to recommend that CMS work with Congress to remove these barriers to the use of telehealth by Medicare beneficiaries.

In this rule, CMS proposes to add certain services, including some of the services added during the PHE, permanently to the telehealth list as Category 1 services. CMS also proposes to retain certain other PHE services on a temporary basis under a new Category 3. CMS proposes that Category 3 services would remain on the telehealth list through the end of the calendar year in which the PHE ends. Below we make specific recommendations in response to CMS' proposals.

A. CMS Should Reconsider Creation of Category 3 Telehealth Services.

CMS states that it created the Category 3 designation because for many of the services added during the PHE, “the impact of adding these services to the Medicare telehealth services list on a permanent basis is currently unknown,” and that the Category 3 designation will give the public the opportunity to gather data and request that services be permanently added to the list as either Category 1 or Category 2 services.⁴ We respectfully question the accuracy of these statements. It not obvious how CMS distinguished between the proposed Category 1 services and the proposed Category 3 services or that the Category 3 designation will allow sufficient time to gather additional evidence to support a request to permanently add a code to the telehealth list. As proposed, if the PHE is assumed to end in 2021, Category 3 services would remain on the telehealth list only through December 31, 2021, unless a formal request to have the service added as either a Category 1 or Category 2 service was submitted, discussed in the 2022 proposed rule, and finalized. The request for permanent addition to the telehealth list would need to be submitted by February 10, 2021, which may not provide sufficient time to avoid a lapse in access to the services through telehealth after the PHE ends.

We urge CMS to consider adding all of the proposed services to the telehealth list permanently as Category 1 services. If CMS chooses to finalize any codes as Category 3 services, then it should extend the period of time Category 3 services will remain on the telehealth list, at least through the end of the calendar year following the year in which the PHE ends.

B. CMS Should Finalize the Proposal to retain Established Patient Home and Domiciliary Care Services on the Telehealth List as well as Retain New Patient Domiciliary Visit Codes.

For established patients, CMS proposed to add lower level domiciliary care E/M services (99334-99335) and home visits (99347 - 99348) as Category 1 services and to add upper level E/M services in both settings (99336 - 99337 and 99349 - 99350) as Category 3 services. CMS does not propose to retain codes for domiciliary or home visits furnished to new patients (99324 - 99328 and 99341 - 99345) on the telehealth list following the PHE.

Consistent with our comments above, AGS recommends that CMS permanently retain all the domiciliary and home visit codes permanently on the telehealth list. The home and domiciliary settings have always been important sites of service for frail older adults who may have mobility issues that make it difficult to travel to a clinician’s office for care. The PHE has made access to care in those settings even more essential and we advocate that CMS do everything it can regulatorily to retain access to telehealth services in those settings as well as to seek legislative changes to remove statutory barriers to such care. We also recommend that CMS add the codes for domiciliary services furnished to new patients (99324 - 99328) to the telehealth list as Category 1 services. New patient E/M services can be appropriately furnished through telehealth to patients in those settings because support staff are typically available to facilitate use of the audiovisual equipment, if needed.

⁴ 85 Fed. Reg. at 50,100.

C. CMS Should Continue to Provide Reimbursement for Audio-Only E/M Services.

During the PHE, CMS has provided coverage and separate payment for telephone E/M codes (99441 - 99443) that describe audio only services and which had previously been non-covered by Medicare. CMS does not propose to continue to recognize 99441 - 99443 after the PHE ends but identifies the potential for continued need for audio-only interaction between patients and clinicians. CMS has previously established a code for a virtual check-in service of 5-10 minutes and may consider creating a code or codes to describe a more extended service.

AGS agrees with CMS that audio-only services will continue to be valuable means of clinician-patient interaction in some situations. Audio-only services may be a necessary alternative to telehealth for patients who are not comfortable with or do not have the resources (e.g. do not own a smart phone) or know-how to operate various audio and video capable software and mobile applications. Patients with cognitive impairment, low vision, and/or hearing loss face additional barriers that can prevent use of more advanced technology for telehealth services. Audio-only services are an appropriate mechanism for providers to evaluate patients who may be reluctant or unable to seek care in person and can help address healthcare disparities between populations who have access to more advanced technologies and those that do not.

CMS asked for comment on the need to develop coding and payment similar to the virtual check-in but for a longer unit of time and with an accordingly higher value. We believe such coding and payment are necessary to describe instances where clinicians spend significant time providing care through audio-only interaction, although we do not expect care to commonly be provided in this manner. An extended virtual check-in code should be time-based and should be valued consistent with other time-based E/M codes reflecting a comparable amount of clinician time. It should also retain elements of the current audio-only E/M codes that avoid overlap with other E/M services. Specifically, a new extended virtual check-in code should describe a service that does not originate from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or the soonest available appointment. We urge CMS to maintain access to audio-only services by continuing to cover and pay separately for 99441 - 99443 after the PHE ends until such time as codes for an extended virtual check-in service can be developed.

D. CMS Should Allow Practitioners to Determine Appropriate Frequency for Telehealth Visits.

Outside of the PHE, CMS limits the provision of subsequent visits to hospital inpatients by telehealth to once every 3 days and of subsequent nursing facility visits to once every 30 days. Commenters asked CMS to remove the frequency limit on inpatient services telehealth and to revise the nursing facility limit to once every 3 days. CMS agrees with commenters that the frequency of nursing home visits via telehealth should be determined by clinicians based on the specific needs of the patient and is proposing to revise the frequency limitation to one visit every 3 days. CMS does not propose any change to the inpatient limitations.

AGS believes that practitioners should determine the appropriate frequency of visits via telehealth in both the hospital inpatient and nursing facility settings. AGS strongly believes in the value

of a robust clinician/patient relationship and the importance of physically interacting with and observing patients. However, there may be some instances where subsequent visits are better furnished via telehealth, such as to maintain continuity of care. We are not aware of any clinical evidence supporting the three day or 30 day limits and we believe such arbitrary limits could interfere with clinically appropriate care in some cases. Rather than attempting to determine an appropriate frequency limit on telehealth services, CMS should leave the determination of whether a subsequent visit can be appropriately furnished to a patient to the practitioner responsible for his or her care.

E. CMS Should Finalize the Proposed New G Codes to Allow Reporting of Communications Technology-Based Services by Non-Physician Practitioners Who Cannot Independently Bill for E/M Services.

The current G codes for remote evaluation of recorded video or images (G2010) and for a virtual check-in (G2012) specifically describe services furnished by physicians or other qualified health care professionals who can otherwise provide and report E/M services. In this rule, CMS proposes to establish new G codes to describe similar services furnished by non-physician practitioners who do not otherwise report E/M services:

G20X0 Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; and

G20X2 Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion).

High quality coordinated care often involves a team of health care professionals and we agree that a code should be available to report these communication technology-based services when furnished by professionals who do not furnish E/M services. AGS recommends that CMS finalize the codes and values as proposed.

IV. Scopes of Practice and Related Issues (II.G)

During the COVID PHE, CMS adopted several policies that allowed a teaching physician to supervise residents using audio/video real-time communications. Those policies include allowing the requirement for the presence of a teaching physician during the key portion of the service furnished with the involvement of a resident to be met using audio/video real-time communications technology; allowing Medicare to make payment under the PFS for teaching physician services when a resident furnishes Medicare telehealth services to beneficiaries if the teaching physician is present using audio/video real-time communications technology; and allowing the teaching physician to direct remotely using audio/video real-time communications technology the care furnished by up to four residents under the

primary care exception. In this rule, CMS is seeking public comment on whether those flexibilities should be extended either on a temporary basis or be made permanent.

AGS recommends that CMS make permanent the flexibilities described above to supervise residents through real-time audio/video technology. AGS' vision is for a community in which older people have access to high-quality, person-centered care informed by geriatrics principles and free of ageism. The ability to appropriately supervise residents through telecommunications technology will allow us to train more clinicians in geriatric principles and concepts and improve access to practitioners who are trained in caring for older men and women. We believe such supervision can be performed appropriately through real-time audio/video technology.

We also support CMS' proposed changes to the regulations to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs) to supervise diagnostics tests, diagnostic psychological and neuropsychological testing services as allowed by state law and scope of practice as well as to remove requirements that would have specified a level of supervision for PAs beyond that required their scope of practice and state law. These non-physician practitioners are critically important to providing high quality, person-centered care in many practices and those practitioners should be able to care for Medicare beneficiaries to the full extent allowed by state law and scope of practice. We urge CMS to finalize these proposals.

AGS also appreciates CMS' efforts to highlight the role that can be played by pharmacists as members of the primary care team and reiterating that CMS policy allows pharmacists to furnish services that can be billed incident to a physician or non-physician practitioner service. With more than 90 percent of older people using at least one prescription in a month and more than 66 percent using three or more, collaborative care teams caring for those individuals are increasingly incorporating pharmacists into their practices. The valuable medication management service pharmacists provide support overall patient care and management and we appreciate that CMS has confirmed that those services are covered by Medicare under the incident to rules.

V. Payment for Principal Care Management Services in RHCs and FQHCs (section III.C.)

Effective January 1, 2018, CMS established a HCPCS code G0511 (*Rural health clinic or federally qualified health center (rhc or fqhc) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an rhc or fqhc practitioner (physician, np, pa, or cnm), per calendar month*) to recognize care management services furnished by RHCs and FQHCs. Currently, the payment amount for HCPCS code G0511 is set at the average of four national non-facility PFS payment rates for chronic care management and behavioral health integration codes. In the CY 2020 PFS final rule, CMS established separate payment for principal care management ("PCM") services, which include comprehensive care management services for a single high-risk disease or complex condition (HCPCS codes G2064 and G2065). CMS proposed to incorporate these codes into the payment rate calculation for G0511.

RHCs and FQHCs provide essential services, including care coordination and management services, to populations that are otherwise underserved. **AGS concurs with CMS' proposal to include the PCM codes in the valuation for G0511 and urges CMS to finalize the proposal.**

VI. Comprehensive Screenings for Seniors: Section 2002 of the Substance Use Disorder Prevention that Promote Opioid Recovery and Treatment for Patients and Communities Act (“SUPPORT Act”) (section III.E.)

Section 2002 of the SUPPORT Act requires that the IPPE and AWW include screening for potential substance use disorders (SUDs) and a review of any current opioid prescriptions. CMS proposes to revise the IPPE and AWW regulations to include these provisions by incorporating the statutory language into the regulations.

AGS is concerned that some of these elements exceed the type of screening services that otherwise make up the IPPE and AWW services. For example, the “review of any current opioid prescriptions” is defined as including a review of the potential risk factors to the individual for opioid use disorder, an evaluation of the individual’s severity of pain and current treatment plan, the provision of information of non-opioid treatment options, and a referral to a specialist as appropriate. In contrast to this detailed requirement, both the IPPE and the AWW require the detection of cognitive impairment but do not include a comprehensive cognitive evaluation. Such evaluation, if necessary, would be a separate and separately reportable service. Inclusion of more comprehensive evaluation and assessment services into the IPPE and AWW could greatly expand the time and complexity of the services and discourage practitioners from providing them.

We urge CMS to clarify that the required elements are specific to the screening and initial evaluation service and do not include more comprehensive evaluation services that may be performed if the screening indicates that the patient is at risk for potential SUD.

VII. Care Management Services (section II.E.)

AGS has been a long-time and vocal advocate for expanded access to and payment of care management services. We strongly believe that increased care coordination will improve the quality of care provided, increase beneficiary satisfaction with their care, and reduce the growth in Medicare spending. In this rule, CMS proposes several changes intended to address gaps in coding and payment for care management services and we strongly support those efforts, as described below.

A. AGS Supports Proposed Transitional Care Management (TCM) Revisions.

CMS continues its efforts to remove barriers to utilization of the TCM codes and proposes to allow separate payment for 14 additional codes previously identified as overlapping or duplicating TCM services and which cannot be billed with the TCM codes (99495, 99496). The codes proposed for separate payment describe end stage renal disease (ESRD) services (90951, 90954 - 90959, 90963 - 90969) and chronic care management, clinical staff time (G2058).

AGS agrees that the services described by the 14 codes proposed for separate payment do not overlap or duplicate TCM services. Those codes describe services that may support the TCM service but are separate and distinct from TCM and should be paid separately.

B. AGS Supports New Psychiatric Collaborative Care Model Services Code (GCOL1).

CMS proposes to establish a new G-code to describe 30 minutes of behavioral health care manager time: GCOL1 (*Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*). This code would be valued at one half of the work and direct PE inputs for the existing 60 minute CPT code (99493). CMS also proposes that the elements required for 99493 would apply to GCOL1, that GCOL1 could be billed during the same month as Psychiatric Collaborative Care Model and TCM services; and that the service could be furnished under general supervision. AGS supports this proposal and urges CMS to finalize the new code and payment policies as proposed.

VIII. Valuation of Specific Codes (Section II.H)

As described below, AGS supports CMS' proposal related to immunization administration and chronic care management.

A. CMS Should Finalize Proposed Crosswalk for Immunization Administration Codes.

AGS strongly concurs with CMS that beneficiary access to vaccinations is vital to public health. Historically CMS has valued the immunization codes by crosswalking to the RVU values for CPT code 96372 (*Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*). In this rule, CMS proposes to crosswalk the immunization administration codes (90460, 90471, 90473, G0008, G0009, and G0010) to CPT code 36000 (*Introduction of needle or intracatheter, vein*) to better recognize the resources involved in immunizations. We agree that 36000 more accurately captures the clinical labor and resources needed to perform immunizations than 96372 and we urge CMS to finalize the crosswalk as proposed.

B. CMS Should Finalize the RUC Recommend Work Values for the Chronic Care Management Services (CPT code 994XX and HCPCS code G2058).

CMS established payment for HCPCS code G2058 (*Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month*) in the CY 2020 PFS final rule. At the January 2020 RUC meeting, specialty societies requested a temporary crosswalk through CY 2021 between the value established by CMS for HCPCS code G2058 and the value of new CPT code 994XX (with a descriptor identical to G2058). CMS is proposing the RUC-recommended work RVU of 0.54 and the RUC-recommended direct PE inputs for CPT code 994XX. AGS urges CMS to finalize the recommended work RVUS and direct inputs as proposed.

IX. Quality Payment Program

A. Analysis Regarding Performance by Specialty and other QPP Analyses.

The AGS appreciates CMS' continued commitment to work with the medical community to find ways to ease reporting burden on clinicians, while continuing to refine the Quality Payment Program (QPP) to ensure that measurement is meaningful and promotes improvement in quality of care and patient outcomes. The AGS has found, however, that the lack of published data on clinician performance by, for example, specialty, practice setting, practice size, and clinician type, as well as analyses of the QPP's impact on patient care, outcomes, and clinician practice, has made it challenging for AGS to meaningfully comment on some of CMS' proposals. Furthermore, we do not know whether and to what extent CMS' policy proposals are informed by these types of impact analyses.

As CMS prepares to enter the fifth year of the QPP, CMS should have at least three full years of performance data to share and analyze to inform which policies are working, which are not, and whether the program is having any unintended consequences on particular specialties, patient care, or patient outcomes. We urge CMS to publish this data and analyses as soon as possible. Particularly as CMS moves toward significantly adjusting its approach through the MIPS Value Pathways (MVPs) and APM Performance Pathway (APP), it is critical that both the Agency and stakeholders have access to the information necessary to evaluate the impact of these proposed policy changes on clinicians and patients.

B. Geriatrics Specialty Measure Set

The AGS disagrees with CMS's proposal to remove Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Measure # 048) as a quality measure from the MIPS program and therefore the Geriatrics Specialty measure set. Removing the Urinary Incontinence measure will result in excluding up to half of women with urinary incontinence from quality measurement, resulting in loss of opportunity to improve outcomes.

CMS states that its rationale for proposing to remove the measure is that it "is a process measure that only requires an assessment for the presence or absence of urinary incontinence, which by itself may not have a meaningful direct impact on patient care as the screening itself does not indicate a plan of care was implemented. Additionally, the Medicare Part B Claims Measure Specifications collection type has reached the end of the topped out lifecycle." 82 Fed. Reg. 53640. We disagree that the screening may not have a meaningful direct impact on patient care. To the contrary, screening for urinary incontinence is a critical first step in identifying women in need of treatment, intervention, or support for urinary incontinence. Urinary incontinence can also indicate other medical conditions that need to be addressed, such as constipation or urinary tract infections. While we understand CMS' desire to move away from process measures, there are conditions and risks, such as UI, falls, and dementia, for which screening and risk assessments are essential and for which process measures remain the most appropriate means of quality assessment.

The continued inclusion of Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (Measure #50) does not diminish the need for Measure #48, as the intent of the two measures is conceptually different:

- Measure #48 is intended to promote screening for urinary incontinence, recognizing that urinary incontinence is under-reported by patients and under-evaluated by providers.⁵
- Measure #50 is intended to ensure that women who have identified as having urinary incontinence are the evaluated and offered treatment, based on literature showing that patients reporting urinary incontinence are often not evaluated for what is otherwise a treatable condition.

Additionally, the patient populations covered by the two measures are different. Measure #50 is applicable to patients that comprise a subpopulation of those included in Measure #48. The denominator for Measure #48 is all women aged 65 years and older, whereas the denominator for Measure #50 is all eligible women already diagnosed with urinary incontinence.

Removal of Measure #48 undermines the intent of quality measurement related to urinary incontinence — it is not possible to effectively assess quality and clinical outcomes for this highly prevalent, morbid and treatable condition if it remains undetected. In order for Measure #50 to have value, there must also be measurement to assure improved screening for urinary incontinence in the first instance. Relying on Measure #50 alone for quality measurement related to urinary incontinence will exclude nearly half of women over age 65 that have urinary incontinence but have not been diagnosed. Measures #48 and #50 go hand-in-hand because interventions to increase urinary incontinence screenings (as measured by #48) results in higher numbers of women receiving urinary incontinence treatment (as measured by #50). Having Measure #50 without Measure #48 undermines the purpose of improving outcomes for women with urinary incontinence. **For these reasons, CMS should not remove Measure 048 from the MIPS program.**

C. Complex Patient Bonus

The AGS supports CMS’ proposal to increase the number of points available for the complex patient bonus to 10 points for the 2020 performance period/2022 MIPS payment year only due to the anticipated increase in patient complexity and the challenges of providing care to complex patients resulting from the PHE for COVID-19. We urge CMS to make the increase permanent. Given the early evidence of the long-term impact of COVID-19 on patients who “recover,” including heart, lung, and brain damage, blood clot and blood vessel problems, and issues related to mood and fatigue,⁶ we expect that increases in patient complexity will persist long after the PHE ends. Moreover, it is likely that the risks

⁵ See Lukacz et.al.” Urinary Incontinence in Women: A Review” JAMA. 2017;318(16):1592-1604. doi:10.1001/jama.2017.12137; Minassian VA, Yan X, Lichtenfeld MJ, Sun H, Stewart WF. The iceberg of health care utilization in women with urinary incontinence. *Int Urogynecol J.* 2012;23(8):1087-1093; Elstad EA, Taubenberger SP, Botelho EM, Tennstedt SL. Beyond incontinence: the stigma of other urinary symptoms. *J Adv Nurs.* 2010; 66: 2460– 2470.

⁶ See, e.g., Mayo Clinic, COVID-19 (coronavirus): Long-Term Effects, *available at* <https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351> [last visited Sept. 8, 2020].

associated with contracting COVID-19 will remain acute for our members' patient population, who are largely frail, older patients with multiple co-morbidities.

D. Partial QP Election

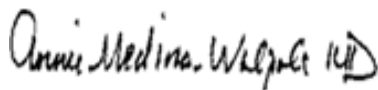
In the proposed rule, CMS solicited comments on whether to allow an APM Entity to make the Partial QP election on behalf of all the individual eligible clinicians associated with such APM Entity. Partial QPs who do not elect to participate in MIPS as a MIPS eligible clinician are excluded from MIPS, and thus, not subject to the MIPS reporting requirements or payment adjustments. We appreciate CMS efforts to make the Partial QP election process less burdensome, but we share the Agency's concerns that its proposal could result in conflicting elections. We agree with CMS that in the case where an APM Entity election conflicts with that of an individual eligible clinician, it would be most appropriate to follow the individual eligible clinician's election. In cases where multiple APM Entities make elections that are not in agreement, and the individual eligible clinician does not make an election, we recommend that CMS make reasonable attempts to contact the individual eligible clinician to confirm his or her election.

More importantly, however, we are concerned that individual clinicians may not know of their APM Entity's (or APM Entities') election(s) and that single elections by APM Entities on behalf of all of its Partial QPs may not reflect the desires of the individual clinicians practicing at such APM Entities. In the preamble to the proposed rule, CMS does not appear to consider that issue. We recommend that, if CMS finalizes this proposal, it require that APM Entities provide advanced, written notice to their clinicians of their Partial QP status elections along with instructions regarding how individual Partial QPs may make a different election so that individual clinicians have the opportunity to make a superseding election if they choose.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,



Annette Medina-Walpole, MD
President



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