



healthcare financial management association

October 2, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1734-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

File Code: CMS-1734-P

Re: Medicare Program: 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; et al.

Dear Administrator Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the *Medicare Program: 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; et al.* (hereafter referred to as the Proposed Rule) published in the *Federal Register* on August 17, 2020.

HFMA is a professional organization of more than 56,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

#### Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the myriad Medicare reimbursement decisions addressed in the 2021 Proposed Rule. Our members would like to comment on the proposals related to the following:

- Telehealth and Other Services Involving Communications Technology
- Refinements to Values for Certain Services to Reflect Revisions to Payment for Evaluation and Management (E/M) Visits
- Merit-based Incentive Payment System (MIPS) Performance Threshold
- Alternative Payment Model (APM) Incentive Payment Qualified Professional Threshold

Please find HFMA members' comments on the following pages.

## **Telehealth and Other Services Involving Communications Technology**

In the Interim Final Rules released on March 30, 2020, and April 30, 2020, CMS used its waiver authority under the public health emergency (PHE) to expand Medicare beneficiaries' access to telehealth services. These changes include but are not limited to expanding reimbursable services that can be provided via telehealth, providing flexibility in supervision requirements to take advantage of telehealth, and expanding sites of service where telehealth can be used to treat Medicare beneficiaries.

In the 2021 Physician Fee Schedule (PFS), CMS proposes multiple changes related to telehealth designed to extend (and where possible make permanent) the expansion of telehealth services made possible under waiver due to the PHE. These changes include adding telehealth services on a temporary and permanent basis, revising caps for telehealth service frequency for beneficiaries in a skilled nursing facility (SNF), allowing clinicians to furnish brief assessment and management services virtually, clarifying issues related to remote patient monitoring and allowing for direct supervision of services by interactive communications technology. **HFMA fully supports CMS's actions to ensure that telehealth services are available to as many Medicare beneficiaries as possible.** Not only will this expand access, but it will also allow beneficiaries to receive high quality, convenient care in the most cost-effective site of service.

However, the rule does not propose to continue recognizing codes for audio-only E/M services for payment under the PFS in the absence of the PHE for the COVID-19. This despite recent data<sup>1</sup> showing that overall, 26% of Medicare beneficiaries lacked either high-speed internet (via desktop or laptop computer) or a smartphone with a wireless data plan. This proportion varied across demographic and socioeconomic groups. For example, half of beneficiaries with income of 100% below the federal poverty level (FPL) lacked digital access, as compared with 12% of those with income 400% or more above the FPL. The proportion of Medicare beneficiaries with digital access was lower among those who were aged 85 or older, were widowed, had a high school education or less, were Black or Hispanic, received Medicaid, or had a disability.

**HFMA members strongly encourage CMS to add the audio-only CPT codes for E/M to the list in the final rule of those codes it will continue to cover after the PHE.** We are deeply concerned that if the agency refuses to do so, it will exacerbate longstanding access issues facing those older, disabled, Black, Hispanic, and/or indigent (and near indigent) Medicare beneficiaries.

**In addition to continuing to cover audio-only visits, HFMA members also request that CMS allow all forms of telehealth visits (including audio-only) to be eligible for disease burden capture (e.g., identification and reconfirmation of Hierarchical Condition Categories, or HCCs), the same as in-person visits after the PHE.**

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<sup>1</sup> Roberts, E.T., and A. Mehrota, "[Assessment of disparities in digital access among Medicare beneficiaries and implications for telemedicine](#)," *JAMA Internal Medicine*, Aug. 3, 2020

**To ensure access to telehealth, HFMA members request that CMS study the cost to deliver telehealth services and use that data to inform Medicare payment rates for both audio only and audio-video E/M services.** HFMA members are deeply concerned that these services are not adequately reimbursed, given that in most instances the cost structure for physician practices to provide virtual visits is not materially different from an in-person visit. Many practices closed their clinics for in-person office visits early in the pandemic and instead provided services virtually. During this time, many physicians and advanced practice clinicians are still “seeing” patients from their office in the physical clinic location where they normally deliver care. Patients are still “virtually roomed” by nurses to improve the efficiency of the visit with the provider. When these nurses are not triaging patients for visits, they are following up on open items in care plans for patients. The practices still have the costs (both staffing and technology) related to scheduling, billing and the electronic health record (many practices’ largest expense). And many practices have now incurred additional expense related to additional hardware and software to support telehealth. In the current environment, opportunities for savings are limited to supplies consumed during the visits. Given the nature of E/M services typically provided virtually, these savings are de minimis.

Furthermore, after the pandemic, few physician practices will be able to go “100% virtual” long-term. Analysis from McKinsey & Company<sup>2</sup> suggests that 24% of office visits could be performed virtually, with an additional 9% performed “near virtually.” This suggests that there may be some cost savings from telehealth on a per-unit-of-service basis; however, it will take several years before practices can reconfigure their clinic footprints and staffing models to realize potential cost savings from reduced facilities and staffing costs.

### **Refinements to Values for Certain Services to Reflect Revisions to Payment for Evaluation and Management (E/M) Visits**

The proposed conversion factor for 2021 is \$32.2605, which reflects a 0.00% update adjustment factor and a budget neutrality adjustment of -10.61%. This unusually large budget neutrality adjustment results from the revaluation of the E/M codes and proposed revalue of certain codes analogous to E/M codes. This budget neutrality adjustment reflects the fact that office/outpatient E/M visits are approximately 20% of the PFS-allowed charges.

Specialty-specific payments impacts vary based on the use and mix of E/M services. Specialties where E/M services represent a greater share of total allowed charges, such as endocrinology (+17%), rheumatology (+16%), hematology/oncology (+14%), and family practice (+13%) would receive the largest increases. In contrast, specialties that have a low use of E/M services such as radiology (-11%), nurse anesthetists (-11%), chiropractors (-10%), pathology (-9%) and physical/occupational therapy (-9%) would receive the largest decrease.

HFMA members are deeply concerned by the chronic underpayment of physicians for services provided to Medicare patients. As illustrated in the graph below, this is a situation that has accelerated over the prior 20 years as a result of the sustainable growth rate (SGR) and flat

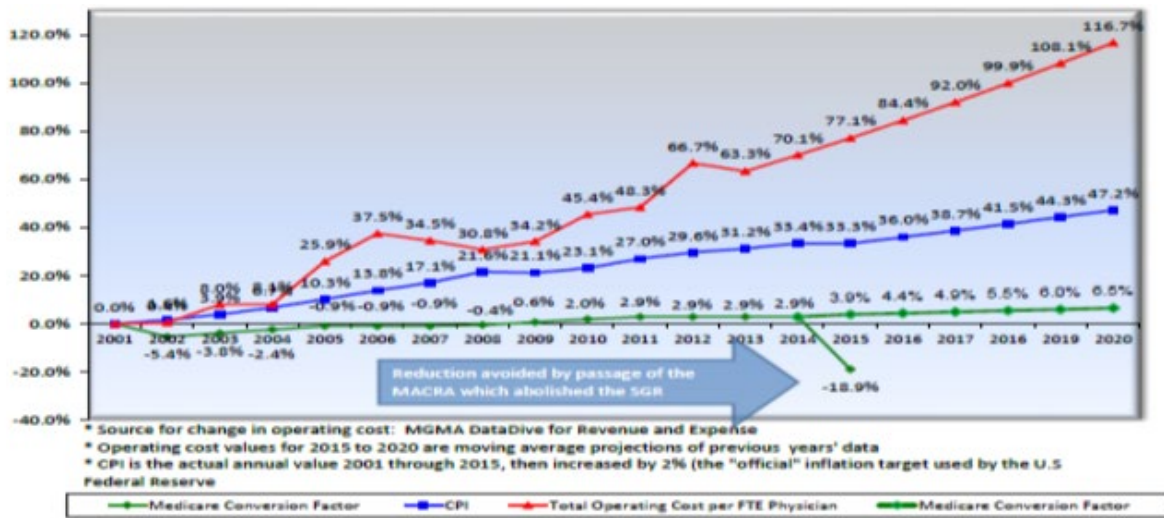
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<sup>2</sup> McKinsey, [“Telehealth: A quarter trillion dollar post-COVID-19 reality?”](#) May 29, 2020.

inflationary updates to the conversion factor that were included in the Medicare Access and CHIP Reauthorization Act of 2015. Based on analysis by the Medical Group Management Association (MGMA), it is estimated that while the conversion factor increased by a cumulative 6.5% from 2001-2020, practice operating expenses per FTE physician increased 116.7%. We believe this unsustainable economic dynamic, coupled with an ever-increasing administrative burden, has been the major driver of physician employment by hospitals and health plans, and acquisitions of practices by private equity groups.

### MGMA

#### Cumulative % Change Since 2001 for Physician Owned Multispecialty with Primary Care Only Groups for Operating Cost, the Consumer Price Index, and Medicare Physician Payments



**HFMA members strongly support the increase in payments for E/M services.** While this is necessary, we do not believe it is sufficient, given the increased payments for E/M services are offset by a significant reduction in the conversion factor. We encourage CMS to work with Congress to increase payments to providers. We believe that this should be done in a manner that encourages participation in alternative payment models (APMs) that reward providers who deliver high quality, cost effective care. We believe this legislation should provide funding to extend the Advanced APM participation bonus program and adjust the thresholds to become a qualifying provider (QP). The revised thresholds should more accurately reflect the existing progress toward "value" and to encourage bringing more patients into these models of care. One example of what this legislation might look like is the Value in Healthcare Act of 2020.<sup>3</sup>

**Furthermore, we are deeply concerned about the magnitude of cuts for some specialties.** Therefore, we encourage CMS to consider phasing this adjustment in over multiple years to minimize the shock to practice finances for specialties that are adversely impacted by the offset required to provide a needed payment increase for E/M services.

<sup>3</sup>U.S. House of Representatives. "[Value in Health Care Act of 2020.](#)"

### MIPS Performance Threshold

CMS believes that disruptions caused by COVID-19 and their downstream effects warrant reconsideration of the performance threshold for Quality Payment Program (QPP) Year 5 (2021 performance year/2023 MIPS payment year), currently set at 60 points. At least some clinicians are likely to experience changes in their ability to participate in MIPS. Reducing the threshold to 50 points from 60 would cause nearly 6% of clinicians to receive positive rather than negative MIPS adjustments applied to their 2023 payments. Small practices would benefit more than previously high performing clinicians. Based on their analysis, CMS proposes that the performance threshold for QPP Year 5 be set at 50 points and makes no changes to the exceptional performance payment threshold of 85 points. **HFMA members support this reduction in the MIPS performance threshold.**

### APM Incentive Payment Qualified Professional Threshold

For a provider to receive the 5% Advanced APM incentive payment it must achieve QP status. The revenue and payment amount thresholds, as required by statute, are provided in the tables below.

**QP Payment Amount Thresholds**

		2019-2020	2021-2022		2023 and beyond	
<b>Medicare Option</b>	QP	25%	50%		75%	
	Partial QP	20%	40%		50%	
<b>All-payer Option</b>	QP	N/A	25%	50%	25%	75%
	Partial QP	N/A	20%	40%	20%	50%
			Medicare	Total	Medicare	Total

**QP Patient Count Thresholds**

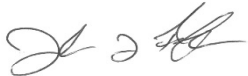
		2019-2020	2021-2022		2023 and beyond	
<b>Medicare Option</b>	QP	20%	35%		50%	
	Partial QP	10%	25%		35%	
<b>All-payer Option</b>	QP	N/A	20%	35%	20%	50%
	Partial QP	N/A	10%	25%	10%	35%
			Medicare	Total	Medicare	Total

Given the disruption to patient volume (and related payments) caused by the COVID-19 PHE, **HFMA members ask CMS to use its waiver authority to reduce the payment and patient account thresholds providers must attain to “QP” for payment year 2022 (based on volumes in CY20) by 15 percentage points for the payment threshold and 10 percentage points for the**

**patient count threshold.** We believe this is necessary because many providers rely on the APM incentive payment to cover the infrastructure costs required to participate in APMs. Failing to make this adjustment will likely reduce the number of providers who are willing to participate in these models in future years. If PHE is extended into CY21, we believe it is appropriate for CMS to make a similar adjustment in the CY22 PFS proposed/final rule.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2021PFS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on these complex issues. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA  
President and Chief Executive Officer  
Healthcare Financial Management Association

#### About HFMA

HFMA is the nation's leading membership organization for more than 56,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.