MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Comments to CMS Region 1 in Response to
Request for Policies to Implement after the Public Health Emergency Ends

On behalf of our 25,000 physician, resident, and medical student members, the Massachusetts Medical Society (MMS) appreciates the opportunity to provide feedback to CMS on policies to implement on a permanent basis once the Public Health Emergency (PHE) ends. Please find below a summary and comprehensive feedback on policies that the MMS recommends CMS implement—these policies will improve patient access to quality care and address workforce shortages and other challenges facing the health care sector. We also invite CMS to view our comprehensive comments on the CY 2021 and CY 2022 Medicare Physician Fee Schedule Proposed Rules, comments on Prior Authorization and Provider Burden, and a Massachusetts tMED Coalition (of which we are a member) telehealth letter. These letters provide additional policy suggestions and details for many of the recommendations mentioned in this document.

Specific policies described in more detail below include:

- Telehealth (pg. 2)
  - Payment Parity – Telehealth at Same Rates as In-Person Services
  - Continued Use of Modifier 95
  - Providers at Home – Enrollment Policies
  - Annual Consent for Telehealth
  - Audio-only Telehealth Coverage
  - Medicare Telehealth Services List – Permanent and Category 3/Interim Additions
  - Telehealth (and Audio-only) for Medicare Advantage Risk Adjustment
  - Virtual Direct Supervision
  - Remote Patient Monitoring and Remote Therapeutic Monitoring
  - Mental Health Telehealth Services: In-person 6-month Requirement and Audio-only
  - Permanent Adoption of Code G2252 – Virtual Check-in
  - Nursing Home and Hospital visit policies
  - Working with Congress on Permanent Telehealth Adoption
- Health Equity (pg. 7)
  - Demographic Data Collection
- Physician Payment (pg. 8)
  - Payment of CPT Code 99072 (for pandemic-related additional supplies, staff time, etc.)
  - Medicare Physician Payment Cuts & Workforce Shortages
  - Quality Payment Program
  - Clinical Labor Pricing Update
- Other Policies (pg. 11)
  - Surprise Billing
  - Prior Authorization/Administrative Simplification

As always, the Massachusetts Medical Society appreciates the opportunity to work with CMS on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org, 781-434-7215 or Yael Miller, Director, Practice Solutions & Medical Economics at ymiller@mms.org, 781-434-7161.

List of Proposed Policies to Extend Past the PHE & Implement on a Permanent Basis

Telehealth	
Telehealth Waivers	MMS urges CMS to make permanent all telehealth waivers granted during the Public Health Emergency (PHE). Specific flexibilities are highlighted below.
Payment Parity – Telehealth at Same Rates as In-person Services	**CMS should maintain payment rates for telehealth services at the same rate as in-person services** at least through the end of the year following the year in which the PHE ends, so that there is sufficient opportunity to gather data on the resources involved in delivering telehealth services—but ideally, CMS will permanently maintain telehealth payment parity. Before the PHE, telehealth services provided by physicians in a non-facility setting, such as a physician office, were paid as if they were provided in a facility setting. Significantly reduced payment rates inhibit the adoption of telehealth, as was the case prior to the PHE. In stark contrast, parity in reimbursement for telehealth services during the PHE helped facilitate the rapid uptick in utilization of telehealth to provide necessary medical care. If CMS allows for reimbursement for telehealth at different rates than in-person services, it will place undesirable incentives for one form of visit or the other. Physicians and patients should decide which type of visit is most appropriate based on medical considerations and not financial considerations.
Continued Use of Modifier 95	During the PHE, CMS has paid for Medicare telehealth services as if they were delivered in person by instructing physicians and practitioners who bill for Medicare telehealth services to report the place-of-service (POS) code that would have been reported had the service been furnished in person. This was done via the use of Modifier "95" to indicate the use of a telehealth system. This modifier allows for greater total reimbursement when the patient is in a location that cannot bill an originating site fee and reimburses the practitioner for providing telehealth technology. **We urge CMS to continue allowing providers to use Modifier 95 for the Place of Service code after the Public Health Emergency ends.**
Providers at Home – Enrollment Policies	Providers have been providing telehealth services from their homes and do not need to update their Medicare enrollment to include their home location nor must their clinic or physician group practice do so if the provider has reassigned his/her benefits. Provider enrollment requirements are regulatory, found at 42 CFR 424.516. During the pandemic, sub-regulatory guidance established this waiver by clarifying that providers do not have to update their enrollments. **CMS should make this guidance permanent under its regulatory authority.**
Annual Consent for Telehealth	In addition, CMS established policy during the PHE that annual consent for telehealth treatment may be obtained at the same time, and not necessarily before the time, that services are furnished. In its fact sheet on flexibilities to fight COVID-19 for physicians and other clinicians, CMS clarified that beneficiary consent should not interfere with the provision of non-face-to-face services and that annual consent may be obtained at the same time, and not necessarily before, services are furnished. **CMS should retain this approach to consent through its rulemaking authority.**
Audio-only Telehealth Coverage	MMS urges CMS to continue payment and coverage for audio-only services. MMS applauds CMS for its decision to approve audio-only visits for the Medicare fee-for-service program during the PHE, which promoted equitable access to care and helped bridge the digital divide. Patients should be able to receive the care they need regardless

	of the technology used to deliver the care. This is important given the digital divide between those who have access to computers and reliable, high-speed internet service and those who do not—and what that means for patients' ability to receive equitable access to care. For example, a Pew Research Center survey found that Black and Hispanic adults are less likely to own a traditional computer or have high-speed internet at home than Whites. The study found "roughly eight-in-ten Whites (82%) report owning a desktop or laptop computer, compared with 58% of Blacks and 57% of Hispanics." Similar statics were found in broadband access, with 66% of Blacks and 61% of Hispanics reporting having broadband access compared to 79% of Whites. However, there were equal percentages of smartphone usage between Blacks, Hispanics, and Whites—80%, 79%, and 82%, respectively.[1] This is also a particularly important issue for elderly and low-income populations who either do not have access to advanced telehealth technology, audio/visual technology, or internet access—or who have trouble navigating virtual visits with both audio and video capabilities. It is vital for these vulnerable populations to be in contact with their physicians and receive timely care. **Therefore, it is essential that audio-only visits continue to be covered by Medicare and they should be paid on par with in-person rates.** Specifically, CMS should ensure Medicare payment rates for audio-only telephone evaluation and management visits are aligned with the payment rates for the established patient office/outpatient E/M visit levels 2–4 (CPT codes 99212–99214). Ideally, Congress will pass legislation allowing for the permanent use and coverage of audio-only telehealth services.
Medicare Telehealth Services List – Permanent Additions	During the PHE, CMS has provided payment for more than 135 additional services when furnished via telehealth and allow additional services to be added on a sub-regulatory basis to the list of Medicare telehealth services. **CMS should use its regulatory authority to permanently retain the expanded list of approved Medicare telehealth services and permanently retain the sub-regulatory process for adding codes to the list of approved Medicare telehealth services.** MMS appreciates that CMS began this process by adding several codes to the Category 1 & 2 permanent telehealth services lists and creating a Category 3 designation for services to be added on an interim basis (see below).
Medicare Telehealth Services List – Category 3 Services (extend through 2023 and permanent consideration)	In the CY 2021 MPFS Final Rule, CMS provided coverage through the end of the PHE for more than 100 services added to the Medicare Telehealth List on an interim basis. These services were given "Category 3" status. As you know, Categories 1 and 2 represent the long-term criteria for additions to the telehealth list, while a "Category 3" was created to allow additions not clearly fitting under Categories 1 and 2. In the CY 2022 fee schedule proposed rule, CMS proposes to extend coverage for the Category 3 services through the end of CY 2023. CMS also solicits comments on certain codes that were given interim but not Category 3 status in the CY 2021 MPFS rule—asking whether these codes should be granted Category 3 status (Table 11 in the CY 2022 proposed rule). **MMS strongly supports extending coverage for Category 3 telehealth services through 2023 and applauds CMS for proposing this extension**—and we urge that it be finalized by CMS. This will allow patients to receive critical care as the future trajectory of the

[1] Perrin A, Turner E. "Smartphones help Blacks, Hispanics bridge some – but not all – digital gaps with Whites." *Pew Research Center*. https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/

	COVID-19 pandemic is better understood. This will also allow more time to study the benefits of providing these services, hopefully outside of the pandemic context. **Ideally, we hope that Congress will enact laws enabling permanent telehealth access, and CMS will consider making coverage of these interim services permanent in response.** In addition, we urge CMS to add the additional services that received interim, but not Category 3 status in the CY 2021 MPFS rule (as outlined in Table 11 in CY 2022 MPFS Proposed Rule) to the Category 3 list through 2023. This will provide physicians greater flexibility in delivering quality care to patients. In particular, we urge CMS to add the CPT codes for telephone evaluation and management services (99441-99443) to the list of Category 3 services which are proposed to remain on the telehealth list through 2023. Were coverage for these services not included in the Category 3 list, and thus eliminated as soon as the PHE ends, it would be counter to the Biden Administration's goals for improving health equity and patient outcomes.
Telehealth for Risk-Adjustment (and Audio-only Risk Adjustment)	**CMS should allow audio-only telehealth visits to be used for Medicare Advantage (MA) risk adjustment in the same way as in-person or audiovisual telehealth visits—and should permanently allow all telehealth services and modalities to be used for MA risk adjustment.** In 2020 and 2021, CMS has allowed video-enabled telehealth to be used to document health acuities for MA risk adjustment purposes during the PHE, but it has not extended that flexibility to audio-only telehealth. It is critical to include diagnoses from all health care services for MA risk adjustment to ensure health care costs are accurately captured, patient benefits are preserved, and premiums are stable. In addition, including all health care visits in risk adjustment is important to provide clinical care teams with the information they need to provide accurate, comprehensive care. The current model of excluding audio-only telehealth visits for risk adjustment exacerbates health inequities for patients without access to audio-visual technologies. Allowing audio-only telehealth visits for MA risk adjustment will be critical for patient access to equitable, quality care. It will also be crucial that telehealth visits—of all modalities—are permanently allowed for MA risk adjustment going forward.
Virtual Direct Supervision	During the PHE, CMS has allowed for the requirement for direct supervision to be met for diagnostic tests, physicians' services, and some hospital outpatient services through the use of real-time, interactive audio/video technology, instead of requiring a physician's physical presence. **The MMS strongly supports this direct supervision policy and recommend it be made permanent**—and at least extended through 2023, like the proposal for Category 3 services. Extending this policy will be especially important for many rural and underserved areas where patients may be unable to access important care services if the only physician available needs to deliver services or supervisions in multiple locations.
Remote Patient Monitoring & Remote Therapeutic Monitoring	**MMS appreciates the RPM flexibilities added during the PHE and urge those to continue past the PHE to allow time for physicians to transition.** For example, CMS will no longer allow RPM services to be provided to a new patient after the PHE. CMS should consider extending this policy until COVID-19 is no longer a threat or longer, so that patients have appropriate access to care as providers transition to new policies—and the RPM policies can be studied from an overall cost and utilization standpoint. • MMS supports CMS' continued use and payment of CPT codes 99453, 99454, 99457, and 99458 which were developed to describe the professional and technical components of remote physiologic monitoring. CMS support of these

	services has had a tremendous impact on expanding access for patients in need of remote monitoring services. • We agree with CMS' clarification that practitioners may furnish RPM services to remotely collect and analyze physiologic data from patients with acute conditions as well as patients with chronic conditions. In addition, CMS introduced new remote therapeutic monitoring (RTM) codes (989X1 – 989X5) in the CY 2022 MPFS proposed rule and proposes payment rates for these new codes similar to the RPM codes. The MMS is generally supportive of these new codes and appreciates the possibilities that RTM will bring, since these codes will allow for new, non-physiologic data to be collected.
Mental Health Telehealth Services – 6-month in-person requirement & audio-only	The *Consolidated Appropriations Act, 2021* (CAA) allows for telebehavioral services in the home and other locations by removing the originating site and geographic location restrictions. The MMS strongly supports these restrictions being waived. However, under the statute, Medicare will provide coverage and reimbursement for telehealth mental health services only if the clinician has conducted an in-person consult with the patient in the prior six months and continues to conduct in-person exams (at a frequency to be determined by U.S. Health and Human Services). The MMS has been actively engaged in congressional advocacy in opposition to this six-month requirement. Moreover, in the CY 2022 MPFS proposed rule, CMS implements the CAA and provides details around its regulatory framework and frequency timeline. CMS proposes to require that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within six months before each telehealth service is furnished for the diagnosis, evaluation, or treatment of mental health disorders. CMS also seeks comment on whether the required in-person, non-telehealth service could be furnished by another physician or practitioner of the same specialty and same subspecialty within the same practice group as the physician or practitioner who furnishes the telehealth service. While we understand that CMS is required to implement this law in response to statute, we have **serious concerns about the requirement that patients have an in-person visit with a physician within six months of each telehealth service.** We are not aware of any evidence supporting the claim that requiring an in-person visit every six months is an appropriate interval nor that it provides a clinical benefit. While statute requires an in-person visit within six months of the initial telebehavioral health service, we believe that CMS has the authority to set the subsequent treatment timeline as they choose and could determine that an in-person follow-up is unnecessary. We are concerned that this arbitrary six-month timeframe could have a serious negative impact on a patient's ability to receive care—there is both a lack of regular access to mental health services in many areas and it could require travel that is unfeasible for the patient, forcing them to forgo necessary care. CMS states that "[w]e chose this interval because we are concerned that an interval less than six months may impose potentially burdensome travel requirements on the beneficiary, but that an interval greater than six months could result in the beneficiary not receiving clinically necessary in-person care/observation." **Physicians are in the best position to understand the clinical needs of their patients and should be given discretion to make the determination whether in-person treatment is needed. The MMS urges CMS to use its regulatory flexibility to ensure that patients can access the care that they need and not finalize this arbitrary six-month in-person follow-up**

	requirement. Moreover, we appreciate the additional flexibility provided by CMS' proposal to allow another physician or practitioner of the same specialty in the same group to furnish the in-person service and are supportive of this proposal being finalized and made permanent. In addition, MMS strongly **supports CMS' proposal to expand the definition of an interactive communications technology for the purposes of telehealth to include audio-only communication technology for mental health services**. However, we continue to express the concern mentioned above around the six-month, in-person visit requirement and believe that the determination of when in-person care is necessary should be up to the discretion of the physician. Furthermore, **we would like additional clarity on how a patient's "home" is being defined—and would encourage CMS to open the requirement to other locations besides a patient's home. We also have concerns about the requirement that the patient be an established patient, and we ask that CMS instead propose a pathway for a physician to establish a new relationship with the patient via audio-only mental telehealth services.** This is especially important given the fact that many mental health providers have begun practicing in a fully remote setting as a result of telehealth success during the pandemic. MMS urges CMS to continue payment and coverage for audio-only services for a wide range of telehealth services, not just mental health-related visits.
Permanent Adoption of Code G2252 – Virtual Check-in	The CY 2021 MPFS Final Rule established on an interim basis code G2252 for an extended virtual check-in (11-20 minutes), which could be furnished using any form of synchronous communication technology, including audio-only. CMS established a payment rate of 0.50 work RVUs. In the CY 2022 Medicare Physician Fee Schedule proposed rule, CMS proposes to permanently adopt coding and payment for code G2252. **The MMS supports permanent adoption of this code, as it will allow greater flexibility for physicians to connect with patients.**
Frequency Limitations & In-person Visit Requirements - Nursing Facilities & Hospital Visits	MMS supports the proposed policy that the frequency limitations on Medicare telehealth visits to nursing facility settings be expanded from once every 30 days to once every 3 days (as was implemented during the PHE). During the PHE, similar frequency limitations were waived for hospital visits, though this is not made permanent in the proposed rule. We urge CMS to consider permanently waiving the frequency limitations on telehealth hospital visits from 30 to 3 days. During the PHE, CMS permitted physicians and NPPs to conduct required visits for nursing home residents via telehealth. The MMS believes that telehealth (including audio-only services) is sufficient for these initial, required visits with the nursing facility patient due to continued exposure risk or other factors and would urge CMS to consider making that policy permanent. Furthermore, MMS recommends that telehealth is sufficient to meet in-person visit requirements for patient orders across the continuum of care.
Working with Congress to Permanently Allow Telehealth	Furthermore, MMS urges CMS to make every effort to work with Congress to obtain permanent, statutory authorization for delivery of Medicare telehealth services to patients wherever they are located—**urging Congress to waive restrictions on the geographic location and originating site.** Although the expansion of the services on the Medicare Telehealth Services List has been very beneficial, the most impactful change to telehealth policies during the PHE has been the ability to deliver services to patients wherever they are located, including but not limited to their home, nursing home, and

	hospitals of all types, etc. While waiting on these statutory policy changes, CMS should urge the Health and Human Services Secretary to continue extending the PHE through CY 2022 or longer to ensure patients can continue getting the care they need without being restricted by their location. In addition, we ask CMS to **work with Congress to enact legislation allowing for the use of audio-only telehealth for all types of telehealth services**—and urge CMS to provide permanent coverage for audio-only telehealth services.
Health Equity	
Demographic Data Collection	The MMS appreciates that CMS is focused on improving data and data collection to improve health equity outcomes. In order to address interpersonal and structural racism, the MMS developed an Anti-racism Action Plan[2] at the end of 2020 to provide the framework to help dismantle structural racism within the MMS, as well as actively work to eliminate racism affecting Massachusetts physicians, patients, and the public. One key goal is to identify opportunities and advocate for policies that work to address racism, poverty, violence, and other social determinants of health. Better demographic data collection and stratification of quality metrics by race and ethnicity will be crucial to understand and address the inequities in health care response to vulnerable populations. In addition, robust data collection and datasets accessible at the point of care can have significant, positive impact on health outcomes. For example, in 2015, Massachusetts passed Chapter 55, legislation that authorized the Massachusetts Department of Health to link multiple, siloed data sets with insight into the opioid crisis. At the time, linking these separate datasets was a novel idea. The database linked mental health data, jail and prison data, vital records, substance addiction treatment data, ambulance encounter information, the state's all-payer claims database, and others. Lessons and insights gained through better demographic data and better sub-population data directly informed subsequent public policy and clinical care—like improved understandings of populations at-risk of opioid related overdose, including those with housing insecurity and histories of incarceration. Improved racial demographic data collection and reporting has highlighted tragic disparities in overdose data, with Black men experiencing a 69% increase in opioid related overdose deaths, the highest increase of any ethnic or racial group. This data is critical in understanding—and ultimately correcting—these tragic disparities in health. In particular, **MMS supports efforts to collect a wide range of demographic data factors. We support advancements in data availability and integration for quality improvement, but the data need to be easily accessible at the point of care and provide actionable information that can inform physician decision-making.** In order to ease the administrative burden associated with reporting the information, **CMS should make every effort to ensure data collection is consistent**. Often, physicians and hospitals are asked to report different types of information in varying forms to multiple government agencies. CMS could ensure the consistency of data by creating standardized datasets for collection of demographic information. In addition, increased data collection needs to be balanced with necessary patient protections and confidentiality. Patients need to feel comfortable reporting the data for it to be effective.

[2]Massachusetts Medical Society Antiracism Action Plan: http://www.massmed.org/Patient-Care/Health-Topics/Antiracism,-Diversity,-and-Equity/MMS-Antiracism-Action-Plan/

860 WINTER STREET, WALTHAM, MA 02451-1411
TEL (781) 893-4610 TOLL-FREE (800) 322-2303 FAX (781) 893-8009 WWW.MASSMED.ORG

Physician Payment	
Payment of CPT Code 99072	In the CY 2021 Medicare Physician Fee Schedule, CMS finalized payment for CPT code 99072 as a bundled service on an interim basis. CPT code 99072 recognizes the financial impact required to maintain safe patient care during the pandemic. It provides payment for costs including additional supplies (like face masks, cleaning products, etc.), clinical staff time for activities such as pre-visit instructions or symptom checks upon arrival, and implementation of office redesign measures to ensure social distancing. **We urge CMS to not pay for CPT code 99072 as a bundled service and instead issue an Interim Final Rule to immediately implement and pay separately for CPT code 99072 with no patient cost-sharing during the PHE.** As suggested by the AMA and reiterated by 128 medical associations in a November 2020 letter, payment for these costs should be fully funded and not subject to budget neutrality. CMS could use remaining money from the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act funding to pay physicians for these costs and/or recognize the decreased expenditures during the early months of the pandemic to waive budget neutrality.
Medicare Physician Payment Cuts & Workforce Shortages	The Massachusetts Medical Society is concerned about several, looming cuts to Medicare physician payment. While many of these cuts are outside the scope CMS' authority, explaining them will provide useful context. We ask CMS to use your authority to halt further cuts to physicians and advocate that your colleagues in Congress do the same. The CY 2022 proposed physician conversion factor (CF) is \$33.5848. This represents a decrease of 3.75% from the 2021 CF of \$34.8931. We recognize that this decrease is not a new cut—this is due to Congressional action expiring, which had deferred a portion of the cuts to the CY 2021 conversion factor until January 2022. We appreciate that CMS did not propose any substantial new cuts to Medicare physician payment in this rule. However, the net result remains an additional reduction in payment to physicians, since the conversion factor has reduced drastically over the last several years and the CF of \$34.8931 is still lower than any time since 1994. Cuts to physician payment are harmful to patient access to care, especially in light of COVID-19, which has created significant financial challenges for physician practices that will persist for years. During the pandemic, many physician practices and health care facilities have seen large decreases in patient visits due to a combination of executive orders and patient fear about their safety and exposure to the COVID-19 virus. Increasingly, physician practices are having to make tough decisions on whether they will be able to sustain their practices and stay open after the pandemic. For example, a survey by Harvard Medical School and developed through a partnership of clinicians, researchers, and public and private entities in Massachusetts found that 20-40% of practices reported consolidating, selling, or closing their practice in 2020 (this statistic was driven mostly by independent practices, including primary care).[3] In addition to the challenges created by the pandemic, workforce challenges are also affecting physician practices, increasing the cost and effort to maintain an adequate

[3] Song Z, et al. "Economic and Clinical Impact of Covid-19 on Provider Practices in Massachusetts." *NEJM Catalyst Innovations in Care Delivery.* https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0441

	clinical and office staff. For example, it is already difficult for physician offices to maintain staff, since many front office staff, medical assistants, registered nurses, or technicians are finding jobs elsewhere that have lower health risk or less stress. Additional Medicare pay cuts threaten the ability for practices to provide competitive pay for their staff. This could lead to physician practices being understaffed, resulting in less coordination of care with a negative impact on patients and the quality of their health care experience. Lower physician payment also threatens to push providers towards employment by hospitals or larger health systems (instead of smaller practices), which generally yield lower volume of care and higher cost—and issues with patient access to quality care as a result. The CY 2022 conversion factor reduction further threatens our physicians' ability to sustain their practices and continue to deliver care to their patients—and will undoubtedly undermine patients' access to care. Moreover, physicians will be facing several, additional payment cuts at the end of this year, including a two percent, across-the-board Medicare sequester cut and an approximate four percent cut due to PAYGO (pay as you go) law adjustments required to offset the spending increases from the *American Rescue Plan* COVID-19 budget reconciliation bill passed in March 2021. **Given the financial challenges due to COVID-19 and additional cuts facing physicians at the end of this year, we ask CMS to use its full administrative authority to avert these payment cuts.** We also urge CMS to advocate with your colleagues in Congress to pass legislation mitigating these cuts.
Quality Payment Program	The MMS appreciates CMS' focus on promoting improvements to the Medicare Quality Payment Program (QPP) and introducing a more clinically relevant, less burdensome approach to the Merit-based Incentive Payment System (MIPS) via the new MIPS Value Pathways (MVPs). We support improvements to value-based payment mechanisms under the QPP. However, it is important to note that continuous changes to program terminology, participation and reporting requirements, and other measures can significantly add to physicians' administrative burden. These continuous changes can make it more difficult for physicians to formulate practice goals and better measure and improve their own performance, which can impact patient care. At a high-level, the **MMS urges CMS to reduce physician burden by making the program simpler and more streamlined—and make the program more predictable, adaptable, and accessible across all specialties, while also striving for an optimal assessment of the quality of patient care.** In addition, the nine percent MIPS reduction for providers who do not report or do not reach the threshold is far too great, particularly given the other, substantial Medicare payment cuts physicians are facing this coming year. Regarding specific policies, the MMS applauds CMS for the flexibilities that it implemented during the COVID-19 pandemic, especially related to the Merit-based Incentive Payment System (MIPS) and asks for those to be implemented for the 2021 performance period. Specifically, **we urge CMS to automatically apply the Extreme and Uncontrollable Circumstances Hardship Exception for the 2021 MIPS Performance Period, so physicians are held harmless from the nine percent MIPS penalty due to the significant, ongoing disruptions that the COVID-19 PHE is having on physician practices.** The COVID-19 pandemic remains an ongoing crisis and disruptive to the fair and accurate evaluation of physician performance in MIPS.

<table>
<tr><td></td><td>In the CY 2022 fee schedule, CMS proposes updates the MIPS Value Pathways (MVPs) criteria, proposes an implementation timeline for MVPs (CY 2023), and introduces the first set of proposed MVPs. The Department also sets a date to potentially sunset traditional MIPS (the end of 2027 performance and data submission periods). The proposed MIPS performance threshold for the 2022 performance year is increased to 75 points and the exceptional performance threshold to 89 points. In response, the MMS suggests the following (as proposed by the AMA):

Because of the challenges physicians faced during the pandemic, we also urge CMS to exercise the Extreme and Uncontrollable Circumstances hardship exception policy and related authorities to lower the performance threshold from the proposed 75 points and reweight the Cost Performance Category to the weight that it was prior to the PHE in 2019, which was 15%.
CMS should encourage subgroup compositions of multiple specialties, across multiple locations, and in various sizes to achieve the MVP’s goals of improving care and reducing avoidable costs.
CMS should work with specialty societies and other MVP developers to develop and test new and innovative cost measures that are clinically appropriate for an MVP.
CMS should finalize its proposal to provide detailed, comparative feedback to physicians who participate in the same MVPs. CMS should also provide easy, affordable ways for physicians to access and analyze Medicare claims data to identify opportunities to reduce spending, measure the impacts of care delivery changes, and quickly identify when services for patients need to be changed.
We support CMS’ goals of focusing the Promoting Interoperability (PI) program on interoperability and improved patient access to health information as opposed to burdensome, prescriptive data capture and measurement policies. We urge CMS to continue to limit regulatory requirements in the PI program as long as physicians can share data among themselves and with their patients.
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<tr><td>Clinical Labor Pricing Update</td><td>CMS proposes updates to the clinical labor pricing data, which has not been updated since 2002. These pricing updates will impact the Practice Expense relative value units (RVUs). This proposal comes on the tail of updates to supply and equipment pricing— CY 2022 is the final year of a four-year transition for new supply and equipment pricing. In part, the updates to the clinical labor pricing are being proposed to address potential distortions in the allocation of direct practice expenses that would result from updating the supply and equipment pricing (with no corresponding update to clinical labor pricing). Like with the supply and equipment pricing, CMS is considering a four-year transition to ease in the clinical labor pricing updates.

Overall, the MMS is supportive of the proposed policy to update the clinical labor pricing data and we agree that the four-year transition is reasonable, given the impact of this change. Furthermore, we agree that the United States Bureau of Labor Statistics (BLS) wage data would to be the most accurate source for clinical labor pricing data and should be used. However, CMS should maintain up-to-date data and use the most recent year of available BLS data to determine clinical labor costs. In addition, we urge CMS to reflect any increases in medical practice costs in the conversion factor updates.</td></tr>
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Other Policies	
Surprise Billing	The MMS has been actively engaged in making recommendations to CMS on implementation of the federal surprise billing law, the *No Surprises Act* (NSA). The NSA is federal legislation passed in December 2020 that establishes an independent dispute resolution process for resolving payment disputes, among other provisions. We have submitted to CMS three detailed comment letters and plan to submit a fourth—a response to the IFR Part 2 that was released at the end of September 2021. • MMS submitted on June 24, 2021 detailed comment to CMS on the Qualifying Payment Amount (QPA), an important technical component of the No Surprises Act that dictates an initial calculation used in the out of network billing resolution process. Read more at this link. • MMS submitted additional detailed comment on September 2, 2021 on the Independent Dispute Resolution Process, a portion of the law that ultimately will play a critical role in the promotion of fair payment for care. These comments also included feedback on the Advanced Explanation of Benefits/Good Faith Estimates portions of the law. Read more at this link. • MMS also submitted comments on September 7 relative to the Interim Final Rule Part 1, the first batch of regulatory guidance that details the implementation of the NSA law. In these comments, MMS offered further recommendations on the QPA and IDR processes; weighed-in/asked for clarification on "notice and consent" provisions; and requested clarification regarding the interplay between the federal and related state laws. Read more at this link. In particular**, MMS is concerned that the calculation used for the QPA outlined in the *Requirements Related to Surprise Billing; Part I* rule will not accurately reflect the market.** The QPA is likely to be skewed—and thus, unrepresentative of the market—because of the manner in which contracts are treated in the QPA calculation. The QPA methodology outlined in the IFR explains that each contract represents a single datapoint in calculating the median, rather than individual providers representing the datapoints. Moreover, no weight is given to the number of claims or services provided under the contract in calculating the median contracted rate. Therefore, large contracts (representing many physicians under one contract) and small contracts (representing a small number of physicians) will be weighted equally under this calculation. This will skew the median contracted rate lower to favor the smaller contracts representing few physicians. Explained differently, by using each contracted rate as a datapoint, instead of each contracted physician's rate, it is likely that the QPA will discount contracts representing the majority of physicians in an area. A QPA that is not representative of the market could have significant, negative impacts to health insurance markets and the ability of physician practices (particularly smaller, independent practices) to engage in fair contracting with large health insurance payers and plans. **MMS is also concerned that the independent dispute resolution (IDR) outlined in the *Requirements Related to Surprise Billing; Part II* Interim Final Rule (IFR) does not reflect the IDR process outlined by Congress in the NSA.** The NSA language specifically called for the use of multiple factors to be considered by arbiters in the independent dispute resolution (IDR) process. Instead, the IFR would require arbiters to primarily use the QPA (generally the median in-network rate) as a basis for IDR negotiations—a departure from the bill's language. The process put forth by the CMS and the other agencies involved

	(the Departments of Treasury and Labor) fails to create an impartial and fair dispute resolution system—this will likely lead to consolidation in the health care marketplace, threatening patients' access to care. **We urge CMS and the other Departments to amend the regulation to reflect congressional intent.**
Prior Authorization/ Administrative Simplification	The MMS appreciates the agency's commitment to supporting patients' access to quality care and promoting administrative simplification for health care providers, so that providers can focus more of their time on providing that care. The MMS has long supported policies to reduce delays in care for patients and lessen the administrative burden for physicians that prior authorization processes can cause—and we are largely supportive of the policies outlined in the *Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information* rule. To further improve the rule, we would like to suggest two key areas that could be expanded and strengthened: I. **Include Medicare Advantage plans in the new prior authorization requirements.** The MMS understands that this rule was intended to make changes incrementally, focusing on Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFEs). However, we believe that by excluding Medicare Advantage plans from the new prior authorization requirements, CMS will miss an opportunity to ensure widespread adoption of standards that could have a significant impact on patients. Furthermore, Medicare Advantage plans have more prior authorization requirements and cover a much larger proportion of patients than the plans currently in the scope of what CMS has implemented. We believe the prior authorization policies established by CMS will have a positive benefit to patients. By including Medicare Advantage plans, you will further benefit a significant group of patients—and reduce possible misalignments between Medicaid and Medicare, particularly for patients who are dually eligible in Medicaid managed plans and a Medicare Advantage plan. Including Medicare Advantage plans is also critical to reduce administrative burden—consistency and uniformity across plans will help to streamline provider workflows. II. **Shorten the prior authorization response timeframes further to 24 hours for urgent care and 48 hours for standard care.** The rule is a significant step forward in reducing the prior authorization approval timeframes. CMS is requiring impacted payers (not including QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests, down from 14 days. However, the rule does not go far enough to support patients that cannot afford to have their care delayed for 72 hours to 7 days. According to a survey by the American Medical Association (AMA)[4], 91% of physician respondents said that prior authorization "sometimes, often, or always" results in a care delay—and 74% reported that the prior authorization process can "at least sometimes lead to treatment abandonment." Prior authorization delays should not be a reason

[4] AMA 2019 Prior Authorization Survey: https://www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf

	patients do not receive necessary care. Massachusetts law requires a prior authorization review and notification timeframe of 2 business days for standard care.[5] The Massachusetts policy was successfully implemented in the state without any undue challenge to the sustainability of health insurers. The MMS believes that prior authorization decisions should have an even shorter timeframe of 24 hours for urgent care and 48 hours for standard care, reflecting the policy outlined in the AMA's Prior Authorization Reform Principles[6]—this will help to ensure patients are not unnecessarily delayed in receiving treatments that could be potentially life-saving or alleviate pain and other medical complications. In the AMA survey mentioned above, 24% of physician respondents said that prior authorization has led to "a serious adverse event for a patient in their care." Prior authorization delays should not get between physicians and their patients' care—while the timeline implemented by CMS is an improvement and we support having a policy that requires a response timeframe, 72 hours for urgent care and 7 days for standard care are still far too long for patients to wait for needed care.

[5] AMA 2018 Prior Authorization State Law Chart: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/pa-state-chart.pdf
[6] AMA Prior Authorization and Utilization Management Reform Principles https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf