



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

September 13, 2021

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Re: File Code CMS-1751-P. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

On behalf of the 25,000 physician, resident, and medical student members of the Massachusetts Medical Society (MMS), I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the CY 2022 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 23, 2021 (86 Fed. Reg. 39104). Our comments highlight areas of support, recommendations, and potential concerns. Primary areas of focus in our comments include:

- Concern over the decrease to the conversion factor and additional looming Medicare payment cuts. In light of the financial strain physician practices are already facing due to COVID-19 and ongoing challenges of sustaining a physician practice, we ask that CMS use all of its authority to halt further cuts to physicians.
- Support for the updates to the clinical labor pricing data and the proposal to phase the updates in over four years; however, we ask that CMS maintain and update the data using the most recent data available.
- Support for the extension of Category 3 telehealth services through 2023. We urge CMS to provide as much flexibility as possible to providers and add additional services to the Category 3 telehealth list.
- Concern with the 6-month, in-person requirement for mental telehealth services; we urge CMS to use its authority to not finalize the subsequent in-person visit requirement for mental telehealth services, after the first visit.
- Support for the revised definition of interactive communications technology to include audio-only services for mental telehealth services. We express concern with some of the requirements that the patient be an established patient prior to audio-only telehealth and questions around the definition of “home” and the modifier to verify a physician’s audiovisual technology capabilities.
- Support for the new remote therapeutic monitoring codes, extension of virtual direct supervision, permanent adoption of Code G2252 for virtual check-ins, and other telehealth flexibilities.
- Recommendations on the request for information on health equity data collection.
- Recommendation to issue an Interim Final Rule to cover CPT code 99072.

- Feedback on CY 2022 updates to the Quality Payment Program.

The MMS' recommendations are outlined in more detail below. We also urge the Department to carefully consider the extensive and thoughtful commentary provided by the American Medical Association, which is enclosed with these comments.

The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients.

### **Key Recommendations:**

#### **Conversion Factor and Medicare Physician Payment Cuts**

The Massachusetts Medical Society is concerned about several, looming cuts to Medicare physician payment. While many of these cuts are outside the scope of this proposed rule, it is important to discuss the proposed cuts in this rule (conversion factor reduction) within the larger 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).<sup>1</sup>

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 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

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<sup>1</sup> 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>

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.

### **Clinical Labor Pricing Update**

In the proposed rule, 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.

### **Telehealth and Other Communications Technologies**

#### ***Telehealth***

The MMS appreciates CMS' efforts to respond to the challenges presented by COVID-19 and provide crucial flexibilities for telehealth policies during the Public Health Emergency (PHE). These expanded policies allowed patients to get the care they needed during the PHE.

The flexibilities and enhancements that have been granted during the COVID-19 PHE have accelerated the utilization of telehealth across the United States and in Massachusetts. COVID-19 telehealth policy changes have ensured that Massachusetts residents have access to critical health care services while supporting necessary precautions to limit exposure to COVID-19, reduced the stress and burden of traveling to appointments (including the cost of tolls and parking and time lost from work), allowed continued social distancing, and preserved personal protective equipment for the health care workforce. Telehealth (including audio-only services) has been a powerful tool to increase equitable access to care for all residents of the Commonwealth and promote the principles of health equity and health justice.

Telehealth utilization grew immensely during the pandemic. According to FAIR Health, telehealth accounted for 6% of all claims submitted across payers in August 2021, up from just .08% just two years ago.<sup>2</sup>

Telehealth appointments have also improved patient compliance with appointments and reduced no-shows—one Massachusetts health system reported that telehealth show rates had been 89% during the first half of 2020 versus the show rate of 80% for in-clinic-only visits during the previous year. Moreover, a study by an MMS member (at the UMass Memorial Hahnemann Campus) published in the *Journal of the American Academy of Dermatology* shows that compared to visit rates in-clinic, telehealth visits “had significantly lower no-show rates, with the greatest reductions seen for Black or African American, LatinX, and primary non-English speaking patients.”<sup>3</sup>

Telemedicine’s ability to improve show rates extends beyond increased access to necessary care: these efficiencies also translate to high-value, lower cost care. Since telehealth changes will be subject to Medicare Physician Fee Schedule budget neutrality provisions, it is important to note that expanding and making permanent telehealth flexibilities will not add substantial cost. For example, a report by the Taskforce on Telehealth Policy (convened by the National Committee for Quality Assurance, Alliance for Connected Care, and the American Telemedicine Association) found that “the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded”.<sup>4</sup> The authors argue that telehealth may improve costs because of fewer missed appointments (no-show rates) that improve compliance, fewer costly Skilled Nursing Facility patient transfers to hospitals/emergency departments, and increased use of transitional care management that cuts readmissions—however, they note that additional data after the PHE would be helpful for a fuller assessment on long-term cost of telehealth.

Due to the success of telehealth since the start of the PHE, the MMS urges CMS to continue to strengthen telehealth policies and make permanent many of the flexibilities granted during the COVID-19 PHE. 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

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<sup>2</sup> FAIR Health Data on Telehealth Utilization by State: <https://www.fairhealth.org/states-by-the-numbers/telehealth>

<sup>3</sup> Franciosi EB, Tan AJ, Kassamali B, O’Connor DM, Rashighi M, LaChance A, Understanding the Impact of Teledermatology on No-Show Rates and Healthcare Accessibility: A Retrospective Chart Review, *Journal of the American Academy of Dermatology* (2020), doi: <https://doi.org/10.1016/j.jaad.2020.09.019>.

<sup>4</sup> NCQA Taskforce on Telehealth Policy (TTP): Findings and Recommendations, <https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-ttp-findings-and-recommendations/>

telehealth services—and urge CMS to provide permanent coverage for audio-only telehealth services.

Specific telehealth recommendations are listed below:

**I. Extension of Category 3 Telehealth Services through 2023**

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. CMS did not add any new services to the permanent Category 1 or 2 lists in the CY 2022 MPFS and explained in detail why they decided to not add any of the codes recommended and submitted by the public over the past year to the Category 1 and 2 lists. However, in this 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 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 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.

**II. Mental Health Services – Six-month Requirement**

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.<sup>5</sup>

Moreover, in the CY 2022 MPFS proposed rule, CMS implements the CAA and provides details around its regulatory framework and frequency timeline. In particular, 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.**

### **III. Audio-only – Mental Health and Other Telehealth Services**

The proposed CY 2022 MPFS establishes a new definition of “interactive communications technology” to allow for use and coverage of audio-only mental health

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<sup>5</sup> tMED Coalition Letter to the Massachusetts Congressional Delegation:  
[https://www.massmed.org/Advocacy/Federal-Advocacy/Federal-Advocacy-Letters/Letter-to-Massachusetts-Congressional-Delegation-on-Telebehavioral-Health-Law-\(Section-123-Provision\)/](https://www.massmed.org/Advocacy/Federal-Advocacy/Federal-Advocacy-Letters/Letter-to-Massachusetts-Congressional-Delegation-on-Telebehavioral-Health-Law-(Section-123-Provision)/)

services. However, there are requirements that must be met for this type of service to be furnished. Audio-only for mental health services will be allowed if:

- It is an established patient;
- The patient is at home;
- The provider has capability of doing live video;
- The patient cannot or does not want live video; and
- The patient has had an in-person visit with the telehealth provider in the six months prior.

In addition, CMS is requesting feedback on a modifier for these mental health services furnished via audio-only to certify that a provider has the capability or proper technology to conduct an audiovisual mental telehealth visit.

The 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.** For example, for equity reasons, it may be more beneficial for a patient to conduct a telehealth mental health visit from their car, workplace, or other location of their choosing. Instead of specifying that a patient take part in the visit from their home, it would be better to remove the geographic or originating site requirements. 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. Finally, we have concerns about the clinical appropriateness of the modifier needed to certify that the provider has audiovisual capabilities—and fear this could pose data collection and equity challenges and create an administrative burden for physicians.

In addition, the 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.** MMS applauds CMS for its decision to approve audio-only visits for the Medicare fee-for-service program during the PHE, which has 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 statistics 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.<sup>6</sup> This is also an 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 past the end of the PHE (at least through 2023) and they should be paid on par with in-person rates. Ideally, Congress will pass legislation allowing for the permanent use and coverage of audio-only telehealth services.

Furthermore, **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.** In 2020 and 2021, CMS has allowed video-enabled telehealth to be used to document health acuties for MA risk adjustment purposes, 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. For similar reasons as mentioned above, 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.

#### **IV. 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 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.**

#### ***Virtual Direct Supervision Extension***

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. In the proposed rule, CMS is seeking comment on whether this policy should be extended beyond the end of the PHE, and, if so, whether it should only be extended for a subset of services and whether these services would require a service level modifier. **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.

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<sup>6</sup> 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/>



### ***Remote Therapeutic Monitoring – New Codes***

CMS does not propose any policy changes specific to the Remote Patient Monitoring (RPM) codes in this proposed rule. However, CMS introduces new remote therapeutic monitoring (RTM) codes (989X1 – 989X5) that are effective January 1, 2022 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.**

### ***Artificial Intelligence and Other Innovative Technology***

In the proposed rule, CMS seeks comments on the use of innovative technologies, like artificial intelligence (AI) and software algorithms, in the practice of medicine and various aspects of physician work. As this is an emerging area for physicians, **we ask that CMS issue a separate request for information (RFI) focused solely on the use of these innovative technologies.** This separate RFI would encourage additional stakeholders to comment, who may not be engaged in comments on the physician fee schedule. This would also give physicians additional time to research and understand how these innovative technologies could be used in their practices.

### **Health Equity Data – Request for Information**

In the proposed rule, CMS solicits feedback on how to improve the collection and utility of data around health disparities that arise from social risk factors, including race and ethnicity. CMS requests comments specifically on two areas:

- Future stratification of quality results by race and ethnicity – CMS seeks information on the benefits and challenges of an indirect estimation or “imputed algorithm” approach to assess equity.
- Demographic data collection – CMS seeks comment and information about the ways that hospitals currently collect demographic data (including but not limited to race, ethnicity, sex, sexual orientation and gender identity, language preference, tribal membership and disability status); challenges with collecting this dataset; and quality measures that could address health disparities.

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<sup>7</sup> 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.

The COVID-19 crisis has made it clear that addressing racism is a public health issue. While this pandemic persists, it continually exacerbates the magnitude of health disparities in Massachusetts. It is, perhaps now more than ever, critically urgent to take meaningful strides toward health equity by implementing concrete proposals based on real experience. This pandemic has cast a glaring spotlight on many forms of inequities, as patients from our most

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<sup>7</sup>Massachusetts Medical Society Antiracism Action Plan: <http://www.massmed.org/Patient-Care/Health-Topics/Antiracism,-Diversity,-and-Equity/MMS-Antiracism-Action-Plan/>

underserved communities are disproportionately affected by COVID-19, but systemic racism as a cause of illness and premature death for people of color is not novel.

According to a report by the National Urban League<sup>8</sup> in August 2020, Black and Brown people are nearly three times more likely than white people to contract COVID-19 and one to two times more likely to die from the disease. People of color are also disproportionately affected by chronic health conditions such as diabetes, asthma, hepatitis, and hypertension; infant mortality; maternal mortality and severe morbidity; and police brutality—and also less likely to be insured and have access to health care providers. 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.

## **Impact of Infectious Disease on Codes and Ratesetting – Comment Solicitation**

### ***Payment of CPT Code 99072***

The MMS appreciates that CMS is seeking comments about expenses during the Public Health Emergency (PHE) that could be addressed with new payment rates for new services in future rulemaking. 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

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<sup>8</sup> NPR Article: COVID-19 Death Rate For Black Americans Twice That For Whites, New Report Says: <https://www.npr.org/sections/coronavirus-live-updates/2020/08/13/902261618/covid-19-death-rate-for-black-americans-twice-that-for-whites-new-report-says>

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<sup>9</sup>, 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.

### **Other Recommendations from the CY 2022 Fee Schedule Proposed Rule**

The MMS supports several other policies outlined in more detail in the AMA's comments. Specifically, MMS:

- Asks CMS to clarify billing for the RTM codes. In particular, CMS states that physical therapists cannot bill the new codes because of rules around furnishing and billing "incident to" services. Since physical therapists will be performing services related to these codes, we ask CMS to clarify that the RTM codes are in fact general medicine codes which would allow tasks performed by physical therapy assistants to be billable when provided under the direct supervision of the physical therapist and under the physical therapist NPI number (making incident-to policies irrelevant).
- Supports the RVS Update Committee (RUC) recommendations on specific services that are potentially misvalued and the continued collaboration of the RUC and CMS to identify and review potentially misvalued codes.
- Urges CMS not to require a modifier to be reported for split (or shared) visits. Requiring a modifier adds a level of administrative burden that the new E/M coding structure and guidelines were designed to alleviate. We also urge CMS to work with the CPT/RUC Workgroup on evaluation and management (E/M) to create a proposal to the CPT Editorial Panel to clarify the reporting in CPT Guidelines.
- Opposes CMS' decision not to incorporate the revised office and outpatient E/M values in the global surgical codes and urges CMS to apply the office visit increases to the office visits included in surgical global payment, as CMS has done historically.
- Urges CMS to reestablish the Refinement Panel process, or a similar process, to create an objective, transparent, and consistently applied formal appeals process, that would be open to any commenting organization, and provide stakeholders with multiple avenues of appeal.
- Urges CMS to adopt its proposal to implement the reduced beneficiary coinsurance phase-in for colorectal cancer screening tests as required by the *Consolidated Appropriations Act, 2021*. Further, we urge CMS to conduct patient education and outreach about the changes to their coinsurance for diagnostic colorectal cancer screenings until it is fully phased out in 2030.
- Appreciates and strongly supports the significant updates that CMS proposes to permanently update the Medicare Diabetes Prevention Program (MDPP), specifically the elimination of the Year 2 ongoing maintenance sessions, the redistribution of Year 2

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<sup>9</sup> Letter to CMS on Coverage of CPT Code 99072 <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-11-10-Letter-to-CMS-re-Coverage-of-CPT-Code-99072-11-10-20.pdf>

payments to Year 1, and the waiver of the Medicare provider enrollment application fee. We also recommend CMS to make an additional update to the MDPP by including virtual DPP providers permanently in the program.

- Appreciates CMS delaying the transition away from the Group Practice Reporting Option (GPRO) Web-Interface until 2024 and allowing for a longer glide path but remains concerned with the feasibility of having to begin reporting on one electronic clinical quality measure (eCQM) and all-payer data starting in 2023. We are also disappointed that CMS plans to continue to move forward with its proposals to align Medicare Shared Savings Program (MSSP) quality scoring methodology with the Merit-based Incentive Payment System (MIPS) methodology.
- Supports patient-centered management of pain by clarifying, communicating, modifying, and/or expanding existing care management codes as needed to include patients with chronic pain and significant acute pain, in addition to patients with chronic diseases. We urge CMS to prohibit Part D plans from imposing prior authorization and quantity limits on buprenorphine.
- Urges CMS to finalize its proposal to require electronic prescribing of controlled substances (EPCS) compliance by January 1, 2023 instead of January 1, 2022, and not to require long-term care facilities to comply until 2025. We also urge CMS to finalize all proposed exemptions.
- Urges CMS to finalize its proposal to delay the penalty phase of the Appropriate Use Criteria (AUC) program until the later of January 1, 2023, or the January 1 following the end of the PHE. We also urge CMS to reduce the burden of the AUC, particularly as the program has been superseded by the Quality Payment Program (QPP). Finally, CMS should not move to the penalty phase of AUC until the claims data show a vast majority of all applicable advanced diagnostic imaging claims would meet the requirements to be paid.

## **CY 2022 Updates to the 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 high, 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.

Furthermore, in the rule, 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 reiterates the following, detailed recommendations from 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.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comment and 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](mailto:aicenhower@mms.org) or 781-434-7215.

Sincerely,

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