CONSUMERS F1RST

The Alliance to Make the Health Care System Work for Everyone

September 13, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8013
Baltimore, MD 21244–1850

RE: 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

Submitted electronically via Regulations.gov

Dear Administrator Brooks-LaSure:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care working to change the fundamental economic incentives and design of the health care system. Our goal is to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone. *Consumers First* appreciates the opportunity to provide comments on the Medicare Physician Fee Schedule proposed rule for Calendar Year 2022.

Medicare payment policy often establishes a standard that is then adopted by commercial payers and Medicaid. *Consumers First* offers these comments both to strengthen physician payment, and because the policy changes reflected in this comment letter represent an important step toward realigning the fundamental economic incentives in the health care system to meet the needs of all families, children, seniors and adults across the nation. If implemented, the payment changes being recommended by *Consumers First* have the potential to catalyze the transformational change that is needed to drive high value care into the health care system and across health care markets in the U.S.

The comments detailed in this letter represent the consensus views of the *Consumers First* steering committee as well as other signers, and interested parties. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments focus on the following sections of the proposed rule:

- **II.D – Telehealth and Other Services Involving Communications Technology**
- **IV.A.1.D – Closing the Health Equity Gap in CMS Clinician Quality Programs**
- **VII. D – Changes In Relative Value Unite (RVU) Impacts**

Section II.D – Telehealth and Other Services Involving Communications Technology

The COVID-19 pandemic catalyzed the integration of telehealth services into the mainstream of health care delivery and payment. As stay-at-home orders rippled through the country, driving down visit volume, and therefore revenue for providers across the country, many health care providers and health systems worked to ramp up their ability to deliver telehealth services. Telehealth quickly became both an essential tool for families to continue accessing needed health care services during the public health emergency (PHE) and enabled practices to keep their doors open in the wake of reduced in-person volume. *Consumers First* applauds CMS's ongoing efforts to modify Medicare regulations to ensure the delivery and payment of an expanded set of telehealth services are available to patients during the PHE, and for its efforts to permanently expand telehealth services through Medicare beyond the PHE.

Consumers First supports CMS's proposal allow the use of audio-only communications for the diagnosis, evaluation, or treatment of mental health disorders to established patients in their homes in circumstances when the beneficiary is unable to use, does not wish to use, or does not have access to two-way audio-video technology. Expanding access to additional audio-only services not only ensures that families are able to receive needed health care services both for the duration of the public health emergency and beyond but also is critical to overcome some of the barriers in accessing telehealth services for families to provide more equitable, high value health care. We strongly encourage CMS to continue expanding access to audio-only communication equally to video-enhanced services for additional services beyond the public health emergency. The payment distinction between audio and video telehealth are arbitrary and not clinically supported. Not expanding audio-only communications equally to video-enhanced services only serves to drive up costs and deprive beneficiaries of a clinically important communication modality in their health care. Further, withholding access to audio-only services would only serve to further existing disparities.[1]

Consumers First also supports CMS's proposal to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023 to ensure that families have access to an expanded set of telehealth services and that physicians are able to receive reimbursement for furnishing those services.

Now, 16 months into the COVID-19 pandemic, telehealth services are considered a mainstream modality of care in US health care delivery and payment both for patients and for health care providers. Importantly, because the cost of telehealth services are less than the cost of in-person visits,[2] we are

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[1] The Future of Telehealth: How Audio-Only Services Improve Access and Health Equity. Fierce Health Care March 2021, Available at: https://www.fiercehealthcare.com/sponsored/future-telehealth-how-audio-only-services-improve-access-and-health-equity

[2] Ashwood JS, Mehrotra A, Cowling D, Uscher-Pines. Direct-to-consumer telehealth may increase access to care but does not decrease spending. Health Affairs 2017; 36(3):485-491. doi:10.1377/hlthaff:2016.1130

concerned that an across-the-board extension of telehealth payment parity beyond the PHE that is reliant on the fee-for-service payment model will only incentivize providers to continue to drive up the volume of visits regardless of the costs to the system and value to patients.

Pricing telehealth, and in particular phone calls, in a fee schedule designed and deeply researched over many years to reimburse for the cost and resources used for face-to-face encounters is incompatible with driving high value care. *Consumers First* believes that this is a critical moment for our nation to grapple with how to effectively and sustainably integrate high value telehealth into our physician payment and delivery system by facilitating participation in alternative payment models and ensuring appropriate payment and coverage of high-value telehealth services that are delivered as part of comprehensive, longitudinal care. While we support expanded access to telehealth and the establishment of a permanent and sustainable payment system to support the integration of telehealth into health care delivery, we are concerned by the significant limitations of relying on fee-for-service payment to achieve that goal which was detailed in our comment letter on the CY 2021 Medicare Physician Fee Schedule.[3] Both Congress and CMS have long stated the goal of moving physician payment away from a fee-for-service basis, most notably in that the Medicare Access and CHIP Reauthorization Act of 2015's (MACRA) incentive payments for clinicians participating in Advanced Alternative Payment Models (A-APMs) are designed to encourage clinicians to move toward these models. *Consumers First* acknowledges that temporarily expanding access to telehealth during the COVID-19 public health emergency has been an effective way to both bolster access to care for patients and ensure providers continue to be paid for their services during the pandemic so they can continue providing comprehensive, continuous health care for our nation's families. However, as CMS works to preserve these gains in access, it is also critical to build a payment system that does not push patients towards fragmented telephonic and video "encounters." Effectively building telehealth into alternative payment models is one vital step to achieving this. Particular alternative payment models, by design, shift the economic incentives of provider payments to support the clinician and patient's freedom to choose the most appropriate modality of care including telehealth when appropriate.

Consumers First is also concerned that CMS has not provided sufficient guidance to health care providers on how to provide high quality, high value telehealth visits on a permanent basis. Without clearly defined guardrails to ensure the provision of high value telehealth services, such as services provided by a patient's medical home, *Consumers First* believes there is a significant risk that fee-for-service telehealth services will further fragment care, generate increased volume and result in increased costs for the Medicare program, while having negligible or negative impact on the quality of those services and the health of Medicare beneficiaries.

***Consumers First* recommends that CMS:**

- **Expand access to audio-only communications equally as video-enhanced services beyond the public health emergency.[4]**

Ashwood, Mehrotra, Cowling, and Uscher-Pines, Health Affairs March 2017, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130

[3] Consumers First, Comment Letter to CMS on CY2021 Medicare Physician Fee Schedule proposed rule, October 5, 2020. Available at: https://familiesusa.org/wp-content/uploads/2020/10/Consumers-First-2021-MPFS-comment-letter-10.5.20.pdf.

[4] There may be reasons to prefer video over audio-only communication when medical interpretation is required for patients with limited English proficiency.

- **Promulgate a regulation to ensure all telehealth visits meet quality standards and serve the needs of Medicare beneficiaries.**
- **Integrate telehealth into existing alternative payment models that utilize prospective, population-based payments. By design, alternative payment models shift economic incentives so that payment to providers is based on clinical judgment and improving patients' health, not churning on fee-for-service payment which drives up volume and in turn increases Medicare spending and costs for Medicare beneficiaries. Primary Care First and Direct Contracting Global/Professional tracks are examples of alternative payment models that are able to be scaled nationally, made broadly available to all relevant practice for which a model is designed, and should be the preferred model for paying for telehealth services, rather than through the standard Medicare Physician Fee Schedule.**

Section IV.A.1.d – Closing the Health Equity Gap in CMS Clinician Quality Programs – RFI

In line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," CMS is seeking public input on how to address health disparities through clinician quality programs. Specifically, CMS is seeking feedback on 1) future stratification of quality measure results by race and ethnicity including the use of imputation methodologies to indirectly estimate race and ethnicity, and 2) improving demographic data collection.

Consumers First strongly supports CMS's commitment to addressing health disparities and closing the health equity gap in CMS clinician quality programs, but offers important suggestions for policy change to better reach our shared goals.

Future Stratification of Quality Measures by Race and Ethnicity and Use of an Algorithm to Indirectly Estimate Race and Ethnicity

Consumers First strongly supports CMS's efforts to stratify quality measure results by race and ethnicity. Health care payment and delivery in the U.S. is designed to incentivize high volumes of clinically-based care for sick people rather than to improve all people's health. It does so at exceedingly high cost and at low value for consumers. Efforts to realign the system toward improved overall health and wellbeing are being tested through new payment and delivery models. While these new models of payment and delivery offer promise to reorient the health care system toward achieving better health at lower cost, they also risk exacerbating existing inequities if the goal of racial equity is not centered in the design and implementation of such reforms. Stratifying quality measures by race and ethnicity is a critical step to ensure value-based care initiatives focus on health equity and reducing inequities. Importantly, performance measures will need to be stratified by a broader list of sociodemographic factors to drive meaningful improvements in equity. As a result, it is critical for CMS to indicate both its short-term objectives to stratify performance measures by race and ethnicity, as well as the longer-term vision to stratify measures by additional demographic factors to reduce inequities through health care payment and delivery. ***Consumers First* recommends that CMS:**

- **Stratify all clinical quality measures by self-reported race and ethnicity initially, but to ultimately expand to a broader set of self-reported characteristics that include: primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status.**

- **Move measurement stratification efforts towards stratifying performance and outcomes measures by self-reported race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status.**

Consumers First is concerned about CMS's proposal to use algorithms that would indirectly estimate race and ethnicity to enable the stratification of quality measures until more accurate data sets with self-reported sociodemographic information become available. While we recognize that imputation is a commonly used process in statistics to replace missing data with substituted values, there is significant risk of further exacerbating existing disparities by using this approach.

While new methods for indirectly estimating race and ethnicity have emerged, there continue to be significant limitations in the reliability and accuracy of the estimated data sets. Indirect methods for estimating race typically only consider geocoded and surname data as predictors, can perform poorly among racial minorities, do not adjust for possible errors for specific datasets and are unable to provide race estimates for individuals missing some of this information.[5] The result is that there may be significant underestimates or overestimates within a data set of race and ethnicity information. The goal of stratifying quality measures by race, ethnicity and other sociodemographic factors is to enable providers, policymakers, researchers and other stakeholders to drill down to identify where disparities are occurring in health care delivery or patient outcomes, and determine whether various interventions are addressing those disparities. Importantly, complete data sets are critical to be able to do this accurately. While imputing data for population health level management may be used effectively to enable an individual hospital or clinical practice to gain insights into how it is managing disease-specific conditions within their system, *Consumers First* does not support the use of imputing data to estimate race and ethnicity data for the purpose of stratifying quality measures. Rather than relying on unreliable statistical methods to estimate race and ethnicity data, ***Consumers First*** **recommends that CMS:**

- **Incentivize the collection and use of self-reported disaggregated data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status. The use of Application Programming Interfaces (APIs) is a promising tool that would enable patients to self-report data through certified apps. In addition, The Office of the National Coordinator for Health Information Technology's (ONC) 2015 Edition Health Information Technology Certification Criteria Final Rule, the "2015 Edition" establishes HIT certification requirements that include full disaggregation of race and ethnicity, language, sexual orientation, gender identify and social and behavioral risk factors.[6] CMS should incentivize the use of ONC's 2015 Edition standards for collecting disaggregated data by all clinicians, through all CMS quality programs, and all clinician-focused payment reform efforts.**
- **Incentivize and support clinicians to engage in data collection methods that rely on self-reported data. Self-reported collection of data is the gold standard for collecting**

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[5] Gabriella C. Silva, Amal Trivedi, Roee Gutman, "Developing and evaluating methods to impute race/ethnicity in an incomplete dataset," Health Services and Outcomes Research Methodology (2019) 19:175-195, Available at: https://doi.org/10.1007/s10742-019-00200-9.

[6] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015)

disaggregated data.[7,8,9] To mitigate patient concerns that race and ethnicity or other demographic data may be used in a discriminatory way, providers should explain that the data will be used to improve the quality of care.[10] There are two key approaches clinicians should consider in operationalizing self-reported data methods:

- **Planned Procedures: Conduct surveys with patients prior to the visit as part of the pre-contact, check-in process where patients are asked to complete and verify demographic information, medical history and insurance status;**
- **Urgent Visits: Conduct surveys with patients when patient is stable during the time of insurance verification.**

Improving Collection of Demographic Data

Consumers First strongly supports CMS's efforts to strengthen infrastructure and data systems by ensuring that standardized demographic information is collected to identify disparities in health care delivery outcomes through the CMS Quality Strategy. As noted above, a critical first step in being able to identify underlying disparities in health care delivery - and to then to reduce these disparities - is collecting and reporting on disaggregated data including race, ethnicity, primary language, geographic location, socioeconomic status, gender identify, sexual orientation, age and ability status. For too long, collecting disaggregated data has been identified as an insurmountable barrier in being able to hold the health care system accountable for reducing disparities and improving the health of all people. We applaud CMS for identifying the need to improve demographic data collection across clinicians and hospitals as an essential part of this RFI.

A key element in improving the collection of demographic information is to ensure a robust data system and health information technology infrastructure that is able to surface accurate insights about health disparities and to make data-driven and informed decisions about reducing disparities and advancing health equity. Comprehensive demographic data must be a core element of HIT and data exchange efforts to advance equity and reduce disparities across the CMS enterprise. This will require CMS to take an "equity in all programs and policies" approach and to leverage what other HHS agencies have already developed. The RFI accurately states that "ONC finalized a certification criterion in the 2015 Edition which supports a certified health IT products ability to collect social, psychological, and behavioral health data…however, this functionality is not yet included as part of the certified EHR technology required by the Promoting Interoperability performance category."[11] Indeed, the RFI acknowledged that

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[7] David Baker, Kenzie Cameron, Joseph Feinglass, et all, "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," American Journal of Public Health, Vol 96, No.3, 2006, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470520/pdf/0960532.pdf

[8] Sean Cahill, Robbie Singal, Chris Grasso, et al "Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identify Data in Four Diverse American Community Health Centers," PLoS ONE 9(9):e107104.doi:10.1371/journal.pone.0107104

[9] Haider A, Schneider E, Schuur J, et al. 2019. Comparing Ways to Ask Patients about Sexual Orientation and Gender Identity in the Emergency Room—The EQUALITY Study. Washington, DC: Patient-Centered Outcomes Research Institute (PCORI). https://doi.org/10.25302/7.2019.AD.110114IC.

[10] David Baker, Kenzie Cameron, Joseph Feinglass, et all., "Patient Attitudes Toward Health Care Providers Collecting Information About Race and Ethnicity," Division of General Internal Medicine, Department of Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Ill, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490236/pdf/jgi_195.pdf

[11] 86 FR 39348, July 23, 2021

"the technical functionality exists to achieve the gold standard of data collection."[12] **As a result, *Consumers First* recommends that CMS adopt ONC's 2015 Edition certification standards across all CMS quality programs including CMS's Promoting Interoperability program by ensuring this functionality is part of the certified EHR technology required by the Promoting Interoperability performance category.**

VII.C – Changes in Relative Value Unit Impacts

Central to improving the health and health care of our nation's families is ensuring that primary care providers are valued and empowered in our health care delivery system.[13] Historically low reimbursement for primary care has resulted in an inadequate supply of primary care providers in our nation and reduced access to primary care for many families.[14] Moreover, much of the waste in our health care system is anchored in high-cost specialty care.[15] Office/outpatient evaluation and management (E/M) services — a category of Current Procedural Terminology (CPT) codes most commonly used by family physicians and other primary care providers — encompass activities that require significant investments of the clinician's time, such as taking a patient's history, examining the patient, and engaging in medical decision-making — services that cannot be easily replaced or optimized by advances in technique or technology.

Recognizing the need to reevaluate office/outpatient E/M codes, CMS increased the relative value units (RVU) for E/M services. In the 2021 Medicare Physician Fee Schedule final rule, CMS also finalized an add-on code (G2211, formerly GPC1X) that physicians can bill for complex office visits, including primary care visits. However, Congress acted to supersede CMS by extending a one-time across-the-board payment increase of 3.75 percent for physicians and other professionals, and delaying implementation of G2211 for three years in order to help offset budget neutrality cuts to certain procedural specialists through the Consolidated Appropriations Act of 2021. This congressional action preserved the historical imbalances in payment between primary care and specialists that CMS had attempted to correct, further exacerbating reduction in access to primary care during the pandemic for America's families. Congress's action in this instance also exposes the inherent flaws within the statutory framework for budget neutral relative value units that impede ensuring adequate payment for primary care providers and other essential health care professionals in the US health care system. It is yet another sign that CMS needs to move towards a new payment model for physician payment through Medicare. Unfortunately, the current suite of advanced APMs are too limited. ***Consumers First* recommends that CMS develop and incentivize participation in a broad suite of stable, voluntary models centered on primary care that will help clinicians move from fee-for-service to APMs.**

Thank you for considering the above recommendations. Please contact Sophia Tripoli, Director of Health Care Innovation at stripoli@familiesusa.org for further information.

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[12] 86 FR 39348, July 23, 2021

[13] Naomi Freundlich and staff of The Commonwealth Fund, "Primary Care: Our First Line of Defense," The Commonwealth Fund, June 12, 2013, https://www.commonwealthfund.org/publications/other-publication/2013/jun/primary-care-our-first-line-defense.

[14] Medicare Payment Advisory Commission (MedPAC), "Chapter 5: Issues in Medicare Beneficiaries' Access to Primary Care," in *Report to Congress: Medicare and the Health Care Delivery System*, June 2019, http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf.

[15] Shrank, Rogstad, Parekh, "Waste in the US Health Care System."

Sincerely,

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