



February 1, 2021

The Honorable Liz Richter
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/ Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19

Dear Acting Administrator Richter:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of final rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2021 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We have summarized a subset of recommendations at the onset of this letter that reflect our top priority areas. Detailed explanations for each of these recommendations, along with a broader set of recommendations, are included in the main text of the letter. We are confident that these recommended changes would improve the strength of these policies and help to promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We appreciate this opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine.

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I. Summary of Top Priority Recommendations:

A. Payment and Documentation Proposals for Outpatient Evaluation and Management (E/M) Services

- i. The American College of Physicians strongly supports CMS' decision to move forward with changes to ensure that Medicare payments to physicians better recognize the value of cognitive services in providing quality care to patients.

B. Psychiatric Collaborative Care Model (CoCM) Services

- i. ACP strongly supports this new temporary G code, which will allow clinicians to improve payment accuracy and incentivize the use of psychiatric collaborative care model (PCCM) services, which will lead to improved patient care.

C. Visit Complexity Code

- i. ACP looks forward to working with CMS and the CPT Editorial Panel to find additional solutions to the continued undervaluing of primary care in light of congressional action to delay implementation of this code. ACP requests that the Administration explore making HCPCS code G2211 carrier-priced. This action will allow the code to be paid at the discretion of each individual carrier. We continue to believe there is merit in visit complexity code G2211 and would like to see this code remain on CMS' list for future approval in the PFS.

D. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

- i. ACP strongly supports this action by the Agency to finalize valuations for these selected codes.

E. Prolonged Services

- i. ACP continues to encourage CMS to adopt the CPT revisions for the prolonged services codes exactly as recommended. The finalized action by CMS has the potential to undercut efforts already underway to educate physicians about the changes to these codes and may further strain practices already financially underwater.

F. Telehealth

- i. While ACP is pleased to see that CMS has defined a process for adding additional services to the telehealth list of services, the College continues to strongly encourage CMS to extend several policies promulgated during the COVID-19 public health emergency (PHE) in order to address the many barriers to patient access and physician adoption and use of telehealth prior to the COVID-19 pandemic, as well as properly assess how to foster and strengthen longitudinal, patient-centered care delivery.
- ii. It is essential to maintain expanded access to and use of telehealth services for underserved urban areas, as well as rural communities, and ACP continues to recommend that CMS permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE.
- iii. ACP continues to disagree with some factors considered by CMS as it is currently worded, in that it explicitly excludes telephone E/M. We urge CMS to consider removal of the requirement for the use of two-way, audio/video telecommunications technology so that telephone E/M can continue to be provided to Medicare beneficiaries through the CY in which the PHE ends.
- iv. The College recommends that following the end of the PHE, CMS should continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare-allowed amount of the service. This extension should last at least

through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these visits.

- v. ACP continues to recommend that changes, including the ability for physicians to practice across state lines, remain in place at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these flexibilities.
- vi. As we have stated before, the College strongly recommends that CMS maintain pay parity between telephone E/M claims and in-person E/M visits and between all telehealth and in-person visits even after the PHE is lifted. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these visits.
- vii. ACP does not agree that the establishment of *G2252 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)* on an interim basis is the solution to providing an alternative to telephone E/M visits. ACP strongly disagrees with CMS' conflation of virtual check-ins, of any duration, with audio-only (telephone) E/M, which are completely different. As the College has noted, telephone E/M services are not just a longer virtual check-in service, it *is* an E/M service.

G. Care Management

- i. The College appreciates that CMS filled the void of a lack of guidance on remote physiologic monitoring (RPM) services for Medicare.
- ii. We continue to believe that CMS should extend its interim policy to allow RPM services to be furnished to patients without an established relationship on a permanent basis at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with the option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these services. The College continues to request the same for CMS' interim policy allowing RPM services to be reported for periods of less than 16 days, but not less than two days, so long as the other requirements for billing the code are met. While CMS did not take any action on these recommendations, we look forward to working with CMS to understand the need for additional policy changes in this regard.
- iii. ACP is glad to see that CMS has finalized proposals to expand concurrent billing of transitional care management (TCM) services with other services. We look forward to working with CMS to continue to expand upon these services.

H. Scope of Practice

- i. While CMS did not act on ACP's recommendation that the primary care exception be extended for a period of time after the PHE ends, the College is pleased to see that CMS has taken action to ensure that rural communities have important flexibilities in place to meet patient needs. We support these changes and look forward to working with CMS to understand the need to expand upon these changes through future rulemaking.
- ii. The College welcomes changes to teaching physician regulations and looks forward to working with CMS to understand the need for additional flexibilities in this area.

I. Immunization Administration

- i. ACP strongly encourages CMS to adopt the vaccine valuation recommendations for the new COVID-19 vaccines exactly as provided by the RUC. There is no time to waste in ensuring that all resources are made available to combat this deadly pandemic.

J. Changes to Policies re: Opioid Use Disorder (OUD)

- i. ACP encourages CMS to work with medical societies and through the CPT Editorial Panel process to examine the different resource costs involved with treating different substance use disorders (SUDs) and determine the need for more stratified coding. In the meantime, ACP supports this policy, and we believe it will ensure that more patients will have access to these critical services.
- ii. ACP supports the inclusion of naloxone in the definition of medications to treat OUD, as well as payment for opioid overdose education. Again, this proposal will add additional tools for patients and their care teams to assist them on their journey to recovery. We are encouraged that CMS will move forward with this policy.

K. Payment for Principal Care Management (PCM) Services in Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

- i. ACP supports adding PCM services to the all-inclusive rate paid to RHCs and FQHCs.

L. MIPS Value Pathway (MVP)

- i. ACP supports the overarching concept of MVPs. However, based on the information provided at this point, we are not convinced MVPs go far enough to address the underlying issues or distinguish themselves in a meaningful way from traditional MIPS.
- ii. ACP supports the MVP concept and would like it to move forward as soon as possible. However, we also believe it is important to get it right. If CMS is open to more robust reforms in the future—reforms that ACP and a vast majority of stakeholders support—it should make these changes prior to implementing MVPs.
- iii. While the College appreciates CMS' desire to compare across practices, having a set of mandatory, broad measures across MVPs moves in the opposite direction of enhanced clinically relevant data for patients and physicians and undercuts the intent behind MVPs.
- iv. ACP appreciates opportunities to provide feedback and agrees with CMS that stakeholder engagement is critical to successful development and implementation of MVPs.

M. MIPS

- i. ACP applauds CMS for continuing its broad MIPS extreme and uncontrollable circumstances exceptions for the 2021 performance year (PY). ACP was surprised and disappointed in CMS' decision to reverse its proposal to make a temporary exception to use PY data to set 2021 benchmarks due to COVID-19. We urge CMS to carefully monitor the impact on 2021 data and, pending the results, reconsider a temporary exception to use PY data to set 2021 quality measure benchmarks.
- ii. ACP continues to oppose any increases to the weight of the Cost Category until [longstanding concerns](#) about the validity and accuracy of existing cost measures are resolved.
- iii. All measures should be held to transparent, consistent standards for statistical reliability, actionable impact on patient outcomes, and clinical evidence base.
- iv. ACP cannot support the inclusion of invalid measures, either in traditional MIPS or MVPs. We urge CMS whenever possible to make technical improvements to measures, as opposed to removing them.
- v. While ACP supports reduced reporting burden on clinicians, and does not oppose the use of administrative claims measures in concept, the College has voiced several methodological

[concerns](#) with administrative claims measures to date that we would expect to be addressed before implementation, including a lack of actionability to meaningfully influence patient outcomes, particularly at the individual clinician level.

- vi. ACP strongly supports CMS finalizing a more gradual implementation for the registry testing requirement and delaying testing and data collection requirements.
- vii. ACP supports the finalized changes to the Promoting Interoperability (PI) Category. We also reiterate our [past recommendations](#) to make broader changes to this category to encourage broader innovative uses of CEHRT and Health Information Technology (HIT) by converting performance measures to yes/no attestations, similar to the Improvement Activities (IA) Category.

N. APM Performance Pathway (APP)

- i. ACP supports the goals of the new APP to promote consistency across the QPP and offer flexible reporting options. However, we have serious concerns that requiring all clinicians to report the same six quality measures regardless of APM will inadvertently achieve the opposite effect and instead increase burden. ACP also has several technical concerns with the individual measures and does not support them in their current form, as explained in detail in our [comments](#) on the proposed rule.

O. Medicare Shared Savings Program (MSSP)

- i. ACP urges CMS to freeze the mandatory “glidepath” to higher risk tracks through at least 2021 due to the ongoing PHE.
- ii. The College wishes to underscore the importance of making appropriate adjustments to future MSSP quality measure benchmarks, financial benchmarks, patient attribution, and risk adjustment methodologies to account for the impact of COVID-19.
- iii. We appreciate CMS delaying by one year retiring of the Web Interface as a reporting option.

P. Medicare Diabetes Prevention Program (MDPP)

- i. The College strongly supports several finalized flexibilities and believes that many could help to expand patient access by offering services via telehealth, particularly for those that face transportation or mobility issues, and improve the overall success of the program. We encourage CMS to consider making many of these flexibilities available on a permanent basis.

Q. Advanced Alternative Payment Models (APMs)

- i. The College continues to feel strongly that more broad protections for Advanced APM participants are warranted.
- ii. CMS should be working to introduce new Advanced APMs to meet the anticipated increased demand for fee-for-service (FFS) alternatives due to COVID-19.
- iii. ACP continues to strongly oppose CMS’ new approach for distributing Advanced APM incentive payments that prioritizes payment year TINs.

II. PFS Detailed Recommendations:

A. **Payment and Documentation Proposals for Outpatient Evaluation and Management (E/M) Services**

CMS Finalized Policy: In the 2020 MPFS final rule, CMS finalized acceptance of the E/M codes, CPT guidelines, and RVS Update Committee (RUC) recommended values for the 2021 payment year. These coding changes retained the existing five levels of coding for established patients, reduced the number of levels to four for office/outpatient E/M visits for new patients, and revised the code definitions. CMS also confirmed in the 2020 final rule the decision to allow medical decision-making (MDM) or time to decide the level of office/outpatient E/M visit, along with updated CPT guidelines for both options. In the 2021 final rule, CMS will adopt the actual total times for CPT codes 99202 through 99215 on the date of encounter while moving forward with the valuation and code selection guideline changes.

ACP Comments: **The American College of Physicians strongly supports CMS' decision to move forward with changes to ensure that Medicare payments to physicians better recognize the value of cognitive services in providing quality care to patients.** These changes are especially important at a time when many primary care practices in particular are under severe financial stress due to the COVID-19 pandemic and are at risk of closing their doors. ACP looks forward to working with CMS to ensure that physicians have the tools they need to ensure they are ready for these changes.

B. **Psychiatric Collaborative Care Model (CoCM) Services**

CMS Finalized Policy: In the 2021 proposed rule, CMS proposed establishing a new code, GCOL1 that would describe 30 minutes of behavioral health care manager time. The code would be described as: *"Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional."* CMS had proposed this code to reflect stakeholder concerns that a code did not exist to reflect shorter increments of time spent with patients.

In the final rule, CMS finalized this proposal. This code will now be known as G2214 (*Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*). This code will be valued at 1.90 total facility RVUs. The required elements listed for billing CPT code 99493 will also be required elements for billing G2214. CPT time rules will apply to G2214, as well.

G2214 can be billed during the same month as CCM and TCM services, provided that all requirements to report each service are met and time and effort are not counted more than once. The patient consent requirement would apply to each service independently. G2214 has been added to the list of designated care management services for which CMS will allow general supervision.

ACP Comments: ACP is pleased that CMS has adopted a new G-code for psychiatric collaborative care model (PCCM) services, which would allow clinicians to bill for shorter increments of time. PCCMs are important care management services that are aimed at improving overall patient health. These interim G codes will help to facilitate earlier implementation and will make transitioning to the CPT codes easier once they become available. **ACP strongly supports this new temporary G code, which will allow**

clinicians to improve payment accuracy and incentivize the use of PCCM services, which will lead to improved patient care. We look forward to working with CMS and the CPT Editorial Panel to describe these services and create a new CPT code to ensure this new service is available for billing by all payers.

At the same time, we note that the existing PCCM code set has been flagged by the RUC for review given significant increases in utilization since it was created. These increases in utilization raise questions about whether the code set is being billed appropriately. **We encourage CMS to work with the CPT Editorial Panel and the RUC to ensure that these services are being billed and utilized correctly.**

C. Visit Complexity Code

CMS Finalized Policy: CMS has finalized its proposal to implement a Medicare-specific add-on code (G2211) for E/M office visits that describe the complexity associated with visits that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. However, this code will not be implemented in 2021 due to legislative changes prohibiting its implementation until at least 2024.

ACP Comments: The College continues to agree with CMS that the revised office visit E/M codes still do not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. Additionally, ACP supports CMS' decision to establish the G2211 add-on code to account for these resources. The College agrees that the current GPC1X code descriptor fits its intended purpose and is well-defined. The challenges of the COVID-19 pandemic make it more important than ever that physicians have the necessary resources to care for patients and families impacted by this deadly virus. The visit complexity code promised to be an important tool for primary care practices that have been severely impacted financially by the COVID-19 pandemic. Congressional action has halted the implementation of this code for the foreseeable future. **ACP requests that the Administration explore making HCPCS code G2211 carrier priced. This action will allow the code to be paid at the discretion of each individual carrier. ACP looks forward to working with CMS and the CPT Editorial Panel to find additional solutions to the continuing undervaluing of primary care in light of this action.**

D. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

CMS Finalized Policy: There are a number of codes that are directly cross-walked to office visit E/M codes. Due to the revaluing of the E/M office visit codes, CMS has finalized a proposal to revalue codes that are directly cross-walked. A list of these codes can be found in table 23 of the final rule.

ACP Comments: ACP appreciates CMS' action to finalize an update of the valuations of codes that are directly cross-walked to the office E/M codes. This action will lead to increased valuations and will work to improve patient access to these services. **ACP strongly supports this action by the Agency.**

E. Prolonged Services

CMS Proposal: In the proposed rule, CMS proposed to allow the billing of 99417 when time is used to select the E/M office visit level of coding and when the minimum time for the level 5 office visit (99205

or 99215) is exceeded by at least 15 minutes. For example, practitioners could bill 99417 in conjunction with 99205 (60-74 minutes of total time) when they have spent at least 89 minutes with the patient and with 99215 (40-54 minutes) when they have spent at least 69 minutes with the patient.

However, in the final rule, CMS noted that they will not be finalizing this proposal. The Agency states that it “...continues to believe that CPT code 99417 as written is unclear and that allowing reporting of CPT code 99417 when the minimum required time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time.” Instead, CMS is finalizing policy for 2021 to use G2212 (*“Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact” (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)*) in place of 99417. G2212 will be valued the same as 99417.

ACP Comments: While this action by CMS means that physicians will continue to have a method to bill for prolonged office visits under Medicare, ACP remains concerned that this action by CMS will upend the work done by the AMA CPT Editorial Panel and the RUC to clarify the 99417 code descriptor. Additionally, this action may make null and void education that is already underway on appropriate use of 99417. As you know, many private health insurers follow the lead of CMS in determining what services to cover. Given the Agency’s decision to decline to cover 99417, ACP is concerned that other payers may follow this action. Should other payers follow, their decision, coupled with the fact that many private insurers may decline to cover G-codes, means that physicians may go uncompensated for prolonged services provided to patients. **ACP continues to encourage CMS to adopt the CPT revisions for the prolonged services codes exactly as recommended. The finalized action by CMS has the potential to undercut efforts already underway to educate physicians about the changes to these codes and may further strain practices already financially underwater.** The College looks forward to working with CMS and the CPT Editorial Panel to find a solution to this discrepancy.

F. Telehealth

CMS Finalized Policy: CMS will add a number of services to the list of available telehealth services. CMS distinguishes these codes on a Category 1 basis (services similar to services already on the telehealth list) and a Category 2 basis (services not similar to codes already on the telehealth list).

Below is a list of the codes CMS has added to the telehealth list on a Category 1 basis:

HCPCS Code	Long Descriptor
90853	Group psychotherapy (other than of a multiple-family group)
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using

	total time on the date of the primary service; each additional 15 minutes by the physician or qualified health care professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision-making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision-making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or HCPCS Code Long Descriptor family

99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
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The Agency did not add any codes to the telehealth list on a Category 2 basis. However, CMS is finalizing its proposal to create a new, Category 3 level that would add services to the telehealth list on a temporary basis through the end of the calendar year in which the PHE expires. These services include:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337);
- Home Visits, Established Patient (CPT 99349-99350);
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285);
- Hospital discharge day management (CPT 99238-99239); and
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224-99226).

A list of the extensive, temporary additions to the list of telehealth services can be found on Table 14 of the [final rule](#). CMS added a substantial number of additions to this list following proposed rulemaking. In addition to these expansions, the Agency announced a study which will explore the effects of the COVID-19 telehealth flexibilities to better understand the experiences and learnings of both patients and physicians utilizing these revised policies.

ACP Comments: While ACP is pleased to see that CMS has defined a process for adding additional services to the telehealth list of services, the College continues to strongly encourage CMS to consider extending several policies promulgated during the COVID-19 PHE in order to address the many barriers to patient access and physician adoption and use of telehealth that existed prior to the COVID-19 pandemic, as well as properly assess how to foster and strengthen longitudinal, patient-centered care delivery.

As we have noted in previous communications, ACP supports CMS' policy changes during the PHE to pay for services furnished to Medicare beneficiaries in any health care facility and in their home — allowing services to be provided in patients' homes and outside rural areas. We equally agree that CMS should not jeopardize beneficiary access to added services that have been clinically beneficial. Although limited access to care is prevalent in rural communities, underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants. These patients are more likely to reside in underserved communities that fall within the metropolitan statistical areas that are normally not included in Medicare telehealth reimbursement outside of the waivers offered through the PHE. Research has shown the extensive role that social determinants play in health and health equity, and the pandemic has highlighted how providing expanded access to telehealth services within underserved communities, rural and urban, is an important aspect for infection control, as well as addressing social determinants that exist outside of the pandemic. **It is essential to maintain expanded access to and use of telehealth services for underserved urban areas, as well as rural communities, and ACP continues to recommend that CMS**

permanently extend the policy to waive geographical and originating-site restrictions after the conclusion of the PHE.

As we noted in our comments on the proposed rule, the College supports CMS' decision to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. We agree that the services added under the Category 3 should remain on the list through the calendar year in which the PHE ends. **However, ACP continues to disagree with some factors considered by CMS as it is currently worded, in that it explicitly excludes telephone E/M. We urge CMS to consider removal of the requirement for the use of two-way, audio/video telecommunications technology so that telephone E/M can continue to be provided to Medicare beneficiaries through the CY in which the PHE ends.**

Additionally, ACP appreciates the flexibility provided during the PHE to allow clinicians to waive patient copays. However, it is critical that CMS provide the difference between the Medicare-allowed copay and the waived copay. Many physician practices have had to close their doors during the pandemic, at the expense of patients. **The College continues to recommend that following the end of the PHE, CMS should continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare-allowed amount of the service. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these visits.**

Finally, ACP appreciates CMS' temporary waiver allowing physicians to provide telehealth services across state lines, as long as physicians meet specific licensure requirements and conditions. **ACP continues to recommend these changes remain in place at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further based on the experience and learnings of patients and physicians who are utilizing these flexibilities.** These waivers offer an opportunity to assess the benefits and risks to patient care in addressing the pandemic as well as the ability to maintain longitudinal care for patients who move across state lines. While these waivers do not supersede any state or local licensure requirements, they provide the opportunity to promote state-level action that may further promote more streamlined licensure requirements across the country.

Payment for Audio-only Visits

CMS Finalized Policy: In the March 2020 interim final rule, CMS established interim payment for telephone E/M services for the duration of the PHE. Additionally, CMS increased the valuation of these visits throughout the PHE by linking their valuations to office E/M codes 99212-99214 to recognize the significant physician work required to deliver these services. CMS decided in the PFS final rule for 2021 not to permanently extend coverage and payment for telephone E/M codes 99441-43 beyond the duration of the PHE. At the conclusion of the PHE, these services will not be covered. Instead, CMS has finalized a new virtual visit code as an alternative to telephone E/M visits.

ACP Comments: Telephone E/M services have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video E/M visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do

not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue and while still providing appropriate care to patients. ACP is discouraged to learn that CMS will not continue coverage of telephone E/M services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for telephone E/M services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE. We do not believe that the Agency's decision to finalize a new virtual visit code in place of telephone E/M codes is the solution to responding to gaps in health care delivery identified by the COVID-19 pandemic, especially for patients without access to the technology to utilize telehealth. In fact, ACP believes this decision ignores crucial information that the medical community has learned about telephone E/M visits during this PHE.

For example, evidence suggests that patient visits to ambulatory practices have declined significantly, and despite a rebound, visits remain significantly lower than they were pre-pandemic. Additionally, COVID-19 continues to spread, despite the existence of a COVID-19 vaccine. Therefore, as the need to contain the virus and maintain appropriate social distancing protocols continues, it is unlikely that in-person visits to practices will return to pre-pandemic levels as patients remain uncomfortable with making these in-person visits and physicians schedule fewer patients to be seen in the office. Second, patients have become accustomed to and appreciative of telehealth/telephone visits, and many appreciate the flexibility these visits provide. The transition from in-person visits to the greater use of telehealth and telephone visits during the PHE has provided patients a safe option for receiving equivalent or nearly equivalent care to what they otherwise would receive in an in-person setting. Third, physicians will have to adjust their workflows and practices to allow for appropriate social distancing protocols and prevent patient infection. This again will mean that, in many cases, practices will not be able to maintain economic viability without maintaining payment for these remote services.

Furthermore, the College also believes that audio-only E/M visits have an added advantage over audio-visual visits by avoiding many issues associated with connectivity and broadband throttling. Additionally, the practical impossibility of excluding audio-only services must be noted. It is often the case that a patient, especially in a rural or disadvantaged community, cannot support audio-visual technology. The video visit must be converted to audio when this occurs, which would then deny the physician pay parity following the conclusion of the PHE. This could result in a deep equity issue across different populations as millions of beneficiaries could be left without care – individuals who benefit the most from audio-only services. As parts of the country struggle with broadband connectivity and smartphone capabilities to support video visits, particularly in rural and economically-disadvantaged communities, ACP encourages CMS to use telephone E/M services as one method to support these communities in their efforts to care for patients. **The College strongly recommends that CMS maintain pay parity between telephone E/M claims and in-person E/M visits and between all telehealth and in-person visits even after the PHE is lifted. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these visits.**

As noted above, ACP does not agree that the establishment of G2252 (*Brief communication technology-*

based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion) on an interim basis is the solution to providing an alternative to telephone E/M visits. **Rather, CMS should work to expand coding options for telephone E/M services through the use of G-codes. ACP strongly disagrees with CMS' conflation of virtual check-ins, of any duration, with audio-only (telephone) E/M, which are completely different. As the College has noted, telephone E/M services are not just a longer virtual check-in service, they are an E/M service.** Patients without access to telehealth need options that provide reliable, remote means to communicate with their physician following the end of the PHE.

Finally, while ACP does not support the use of G2252 as a replacement for telephone E/M visits, it should be noted that the current plan to cross-walk G2252 to the current value of 99442 is significantly flawed. The physician work RVUs associated with G2252 and 99442 (work RVU: 0.50) are considerably lower than the value of 99442 established by CMS through interim final rulemaking for the duration of the PHE. During the PHE, CMS has established a work RVU for 99442 that is cross-walked to the value of 99213 (work RVU: 1.30). Use of G2252 would provide considerably less resources to physicians to enable them to provide care for their patients. This may lead to many physicians deciding against using G2252, despite CMS' best intentions. Once again, rather than adopting a substitute, **the College strongly recommends that CMS maintain pay parity between telephone E/M claims and in-person E/M visits and between all telehealth and in-person visits even after the PHE is lifted. This extension should last at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with an option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these visits. The College looks forward to working with CMS and the CPT Editorial Panel to ensure that coding and payment options for these services are made widely available.**

Direct Supervision

CMS Finalized Policy: In the office setting, "direct supervision" means the physician (or other supervising practitioner) must be present in the office and immediately available to furnish assistance and direction to the clinician performing the service throughout the duration of the procedure. Direct supervision does not mean that the physician/supervising practitioner must be present in the room. In an effort to limit the exposure of COVID-19, CMS proposed to extend until the end of 2021 the ability of supervising physicians or practitioners to use interactive audio/video real-time communications technology to supervise directly. The Agency has finalized an extension of this policy through the end of the CY in which the PHE ends, or December 31, 2021. CMS did not finalize any policy to permanently extend this. This provision applies to qualified health professionals (QHPs)/clinicians, but not residents.

ACP Comments: Although CMS did not finalize a policy to permanently extend this flexibility beyond the end of the PHE, the College is pleased to see CMS respond to the needs of physicians by extending the flexibility to continue to provide direct supervision via interactive audio/video technology through the end of 2021. The College continues to support an extension of this flexibility even further based on the experience and learnings of patients and physicians who are utilizing these supervision flexibilities. ACP believes that providing for a permanent flexibility in this space supports the expansion of telehealth services and protects frontline workers by allowing appropriate social distancing measures. Similarly, we

believe that clinicians should feel empowered to supervise clinical staff virtually, at their discretion, regardless of whether there is a declared PHE. **The College looks forward to working with CMS to provide flexibility in this regard as we learn more about the impact of the COVID-19 pandemic.**

G. Care Management

Remote Physiologic Monitoring (RPM)

CMS Finalized Policy: In the final rule, CMS clarified its payment policies related to RPM services codes 99453, 99454, 99091, 99457, and 99458. CMS also clarified that following expiration of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished – ending its interim policy permitting RPM services to be furnished to new patients. The Agency also finalized policy allowing consent to receive RPM services to be obtained at the time RPM services are furnished.

CMS' final rule further provides for a number of modifications to RPM codes beginning in 2021:

- Allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision;
- That medical devices supplied to a patient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported;
- After the COVID-19 pandemic ends, 16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454;
- Clarifying that only physicians and NPPs who are eligible to furnish E/M services may bill RPM services;
- Noting that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions; and
- Clarifying that for CPT codes 99457 and 99458, an "interactive communication" is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.

ACP Comments: The College appreciates CMS for filling the void of a lack of guidance on RPM services for Medicare. RPM services have been a critical component of care, especially during the COVID-19 pandemic. ACP is pleased to see the Agency finalized a number of policies that will be beneficial to both patients and their care teams. These changes expand access to services at an important time, as patients and their care teams need additional resources to meet current challenges. These changes will help relieve physician burden and allow physicians more time to treat complex patient issues that require more than remote monitoring. **We continue to believe that CMS should extend its interim policy to allow RPM services to be furnished to patients without an established relationship on a permanent basis at least through the end of 2021, or until such a time when effective vaccines and treatments are widely available, with the option to extend it even further, or consider making permanent, based on the experience and learnings of patients and physicians who are utilizing these services. The College continues to request the same for CMS' interim policy allowing RPM services to be reported for periods of less than 16 days, but not less than two days, so long as the other requirements for billing the code are met. While CMS did not take any action on these recommendations, we look forward to working with CMS to understand the need for additional policy changes in this regard.**

Transitional Care Management (TCM)

CMS Finalized Policy: The Agency finalized its proposal to increase the valuations of TCM services. CMS also finalized a proposal to allow the concurrent billing of certain codes alongside TCM services (see table 18 in rule). The list of these codes is as follows:

Service Type	CPT Code	Descriptor
End Stage Renal Disease Services (for ages less than 2 months through 20+ years)	90951	ESRD related services with 4 or more face-to-face visits per month; for patients younger than 2 years
	90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2-11 years
	90955	ESRD related services with 2-3 face-to-face visits per month; for patients 2-11 years
	90956	ESRD related services with 1 face-to-face visit per month; for patients 2-11 years
	90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12-19 years
	90958	ESRD related services with 2-3 face-to-face visits per month; for patients 12-19 years
	90959	ESRD related services with 1 face-to-face visit per month; for patients 12-19 years
	90963	ESRD related services for home dialysis per full month; for patients younger than 2 years
	90964	ESRD related services for home dialysis per full month; for patients 2-11 years
	90965	ESRD related services for home dialysis per full month; for patients 12-19 years
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90967	ESRD related services for dialysis less than a full month of service; per day; for patients younger than 2 years
	90968	ESRD related services for dialysis less than a full month of service; per day; for patients 2-11 years
	90969	ESRD related services for dialysis less than a full month of service; per day; for patients 12-19 years
Complex Chronic Care Management Services	G2058 (Beginning CY 2021, CPT code 99439)	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

ACP Comments: ACP applauds CMS' decision to remove restrictions that prevent the concurrent billing of ESRD and CCCM with TCM services. This change will lead to increased valuations and will work to improve patient access to these services. **ACP is glad to see that CMS has finalized these proposals. We look forward to working with CMS to continue to expand upon these services.**

H. Scope of Practice

Primary Care Exception Flexibilities

CMS Finalized Policy: Before the COVID-19 PHE, CMS' primary care exception allowed residents in teaching hospitals to provide and teaching physicians to bill for low- to mid-level complexity outpatient E/M services when a teaching physician was not present. CMS has finalized this interim policy, as well as to allow for:

- Teaching physicians to direct and review the services furnished by a resident during or immediately after the visit remotely using audio/video real-time technology; and
- Medicare to pay the teaching physician for additional services under the primary care exception, including all levels of office E/M codes, audio-only telephone E/M services, transitional care management, and communications technology-based services.

The Agency emphasized that residents will have to document that the services are separate, and that they are allowed by law to practice medicine by the state in which services are provided.

At the conclusion of the PHE, CMS has established new policy around the primary care exception that will apply to residency training programs that are located outside of an OMB-designated metropolitan statistical area (MSA), also known as a rural area. At the conclusion of the PHE, residents outside of an MSA may provide an expanded array of services that include:

- Services described by CPT codes 99421-99423 and 99452;
- Services described by HCPCS codes G2010 and G2012; and
- Medicare telehealth services (99202, 99203, 99211, 99212, and 99213).

Additionally, at the end of the PHE, CMS will terminate the inclusion of CPT codes 99204, 99214, 99205, 99215, 99495, and 99496 from the primary care exception for all settings.

ACP Comments: The College welcomes these changes by the Agency that will grant attending physicians and residents/fellows additional flexibilities that prioritize patient safety and meets them where they are. These important steps promote efficient patient care and allows physicians and supervisees to work together unencumbered by social distancing restrictions. **While the Agency did not act on ACP's recommendation that these modifications should continue for a period of time after the PHE ends, the College is pleased to see that CMS has taken action to ensure that rural communities have important flexibilities in place to meet patient needs. We support these changes and look forward to working with CMS to understand the need to expand upon these changes through future rulemaking.**

Virtual Presence of a Teaching Physician Using Audio/Video Real-Time Communications Technology & During Medicare Telehealth Services

CMS Finalized Policy: CMS has finalized for the duration of the COVID-19 PHE, the ability of teaching physicians to provide supervision of residents through audio/video real-time communications technology. This is different from direct supervision which applies to QHPs/clinicians.

Additionally, CMS will finalize for the duration of the COVID-19 PHE, the ability for residents to furnish telehealth services to beneficiaries with the teaching physician present using interactive, audio/video real-time communications technology (excluding audio-only).

At the conclusion of the PHE, however, only services furnished in residency training sites that are located outside of an MSA will be eligible under this policy. Though the supervising physician may reside in or outside of the MSA, the Medicare beneficiary must be located outside of an MSA.

ACP Comments: The College welcomes these actions by CMS that will make it easier for physicians and their teams to care for patients. These important flexibilities have provided a critical lifeline for physicians and their teams during the pandemic. ACP is pleased to see that these changes will remain in place for the duration of the PHE. At the same time, we are encouraged that this important change will remain in place for rural practitioners at the conclusion of the PHE. These changes will be critical for practices who so often are limited in what they can provide to patients, simply by the nature of their location. **The College welcomes these changes and looks forward to working with CMS to understand the need for additional flexibilities in this area.**

I. Immunization Administration

CMS Finalized Policy: In the proposed rule, CMS proposed to revalue the immunization administration codes by cross-walking the values of CPT codes 90460, 90471, and 90473, and HCPCS codes G0008, G0009, and G0010, to CPT code 36000. This change would have significantly increased the values of these services to levels that preceded the earlier changes.

However, in the final rule, CMS decided not to finalize the proposal to cross-walk the valuation of CPT codes 90460, 90471, and 90473, and HCPCS codes G0008, G0009, and G0010, to CPT code 36000. This means that the 2019 vaccine payment rates will be maintained, despite concerns that this will have impacts on vaccine purchase, storage, administration, and record-keeping.

ACP Comments: The COVID-19 pandemic has underscored the importance of vaccines to the health and safety of the population at large. Vaccine payment is a critical component to ensuring that patients have access to vaccines. Current vaccine administration costs do not adequately cover the costs of purchasing, storing, monitoring, and administering vaccines. At the same time, the diversity in reimbursement models means that slight decreases in vaccine reimbursement amounts could pose significant consequences for physicians and patients. In last year's comments on the proposed rule, ACP stressed the importance of re-examining and retooling vaccine administration reimbursement. However, ACP is extremely concerned about this finalized policy and that it will not increase the valuation of immunization administration codes as originally proposed. Instead, CMS will maintain existing valuations for vaccine administration codes. Given that CMS has traditionally cross-walked valuations of vaccination administration codes for novel pathogens to existing vaccine administration codes, we are concerned that given the evolving understanding of COVID-19, this practice will not account for the necessary resources to administer these new vaccines. For example, some of the COVID-19 vaccines require an initial dose followed by a booster dose. There remains the distinct possibility that significant physician and clinical staff follow-up may be required between the first and second doses, especially if the patient receives the doses from two unaffiliated practitioners. We are concerned that this work may not be captured in existing vaccination administration codes. **Given the significant patient counseling regarding the COVID-19 vaccine that is expected—and, in fact, is already underway, as patients reach out to their internal medicine physicians with questions—as well as the record-keeping and vaccine storage requirements, we strongly urge CMS to ensure prompt payment of vaccine administration and other related claims and work hand-in-hand with physician practices to ensure they have the resources needed to care for patients. Additionally, we strongly encourage CMS**

to adopt the vaccine valuation recommendations for the new COVID-19 vaccines exactly as provided by the RUC. There is no time to waste in ensuring that all resources are made available to combat this deadly pandemic.

J. Changes to Policies re: Opioid Use Disorder (OUD)

Bundled Payments under the PFS for Substance Use Disorders (SUDs)

CMS Finalized Policy: CMS finalized its proposal to modify the code descriptors for G codes G2086, G2087, and G2089 to be inclusive of all SUDs, instead of just OUD. The Agency will consider whether there should be stratified coding to demonstrate any differences in the resource costs associated with providing different SUD services through future rulemaking and collaboration with the CPT Editorial Panel.

ACP Comments: While Medicare patients suffering from OUD now have access to an inclusive set of services, the existing code descriptors may close off access to treatment for patients who may be suffering from a SUD that is not OUD. At the same time, it is important to understand that SUDs manifest in different forms in terms of symptoms, underlying causes, psychology, and treatment needs. **As ACP noted in our comments on the proposed rule, this new policy is a step in the right direction. However, ACP encourages CMS to work with medical societies and through the CPT Editorial Panel process to examine the different resource costs involved with treating different SUDs and determine the need for more stratified coding. In the meantime, ACP supports this policy, and we believe it will ensure that more patients will have access to these critical services.**

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

CMS Finalized Policy: Currently, statute defines covered OUD treatment services to include oral, injected, and implanted opioid agonist and antagonist treatment medications approved by the FDA for the treatment of OUD. CMS has finalized a proposal to revise that definition to include naloxone, which is used to treat opioid overdose. Patients will now be able to receive treatment for opioid overdose at an OTP, and this medication will be covered under the OTP Medicare benefit. CMS is also revising the definition of OUD treatment services under the OTP benefit to include opioid overdose education.

CMS is finalizing two proposed add-on codes, G2215 (formerly GOTP1) and G2216 (formerly GOTP2), to describe the take-home supply of naloxone. The Agency clarified in the proposed rule that in order to bill for HCPCS code G2077 (periodic assessments), a face-to-face medical exam or biopsychosocial assessment would need to have been performed. CMS will allow these assessments to be conducted via telephone for the duration of the PHE, but will only permit them to be offered via telehealth (not audio-only) after the conclusion of the PHE.

ACP Comments: ACP is supportive of lifting barriers to ensure that patients receive access to medications to treat OUD and to reverse overdoses. OTPs are an essential component of care for many people recovering from a SUD. Additionally, opioid overdose education is important for patients to ensure they have the recovery tools needed to be successful. In fact, despite the absence of payment, opioid overdose education already occurs at most OTPs and may be part of treatment plans for patients who are given naloxone. **Therefore, ACP supports the inclusion of naloxone in the definition of**

medications to treat OUD, as well as payment for opioid overdose education. Again, this proposal will add additional tools for patients and their care teams to assist them on their journey to recovery. We are encouraged that CMS will move forward with this policy.

K. Payment for Principal Care Management (PCM) Services in Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS Finalized Policy: CMS will add HCPCS codes G2064 (*at least 30 minutes of PCM services furnished by physicians or non-physicians during a calendar month with certain required elements*) and G2065 (*at least 30 minutes of PCM services furnished by clinical staff under the direct supervision of a physician or non-physician practitioner with certain required elements*) to G0511 (*a General Care Management code for use by RHCs or FQHCs when at least 20 minutes of qualified CCM or general BHI services are furnished to a patient in a calendar month*) as a comprehensive care management service for RHCs and FQHCs starting January 1, 2021. The payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for the RHC and FQHC care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491).

ACP Comments: As noted in our earlier comment letter, ACP agrees that PCM services are an important component of care and should be allowed to be billed by RHCs and FQHCs. **ACP supports moving forward with this change.**

L. MIPS Value Pathway (MVP)

As one of a handful of organizations to submit MVPs for 2021, ACP looks forward to continuing to engage with the Agency on ACP's own preventive care and chronic disease management MVPs, as well as MVPs in general. ACP offered more detailed oral and [written comments](#) on MVPs for the recent CMS Town Hall. **ACP supports the overarching concept of MVPs. However, based on the information provided at this point, we are not convinced MVPs go far enough to address the underlying issues or distinguish themselves in a meaningful way from traditional MIPS.** To do so, CMS must: 1) create more synergy between the performance categories; 2) revamp the Promoting Interoperability (PI) Category; and 3) improve the accuracy of cost measurement. ACP cannot support the inclusion of any measures that ACP's Performance Measurement Committee (PMC) has [rated](#) as invalid.

ACP appreciates that in this rule, CMS states they may revisit larger changes to the PI Category in the future. Similarly, the Agency says they are open to more targeted cost measures, but notes that this would take years to develop. **ACP supports the MVP concept and would like it to move forward as soon as possible. However, we also believe it is important to get it right. If CMS is open to more robust reforms in the future—reforms that ACP and a vast majority of stakeholders support—it should make these changes prior to implementing MVPs.** As CMS alludes to in the final rule, physicians are weary of the near-relentless program changes. Rather than push forward with an MVP concept in 2022 that is more different in name than in structure and delaying larger-scale changes to future years, CMS should take the time to get it right from the outset, even if that means delaying initial implementation of MVPs.

While the College appreciates CMS' desire to compare across practices, having a set of mandatory, broad measures across MVPs moves in the opposite direction of enhanced clinically relevant data for patients and physicians, and it undercuts the intent behind MVPs. Measures that compare across specialties and geographic regions are far too general to be actionable on the part of the individual clinician to improve patient outcomes or to provide patients with meaningful information with which to

compare and select physicians. It is more useful to focus on measures that offer meaningful, clinically relevant information for comparable specialists, diseases, and patient populations.

ACP appreciates opportunities to provide feedback and agrees with CMS that stakeholder engagement is critical to successful development and implementation of MVPs. We appreciate CMS acknowledging the need for a gradual transition and its intent to make MVPs optional, as ACP and other stakeholders have suggested, as well as allowing some choice in measure selection, which is critical to achieving clinical relevance for a diverse array of patients while minimizing reporting burden.

M. MIPS

ACP applauds CMS for continuing its broad MIPS extreme and uncontrollable circumstances exceptions for the 2021 performance year. This critical policy will provide physician practices with needed assurance to continue diverting all necessary resources toward treating patients and bringing about an end to the COVID-19 PHE. We commend CMS for making this important and necessary change. **ACP was surprised and disappointed in CMS' decision to reverse its proposal to make a temporary exception to use performance year data to set 2021 benchmarks due to COVID-19.** While there may be a sufficient quantity of 2019 data with which to make benchmark calculations, the pandemic's untold impact on patient attribution, risk adjustment, and all aspects of performance measurement render comparing pre-pandemic data to 2021 impractical. ACP generally supports prospective performance benchmarks for all the reasons CMS provides in the rule. However, we believe the unique challenges physicians are facing this year and its inevitable impact on performance far outweigh the advantages of using prospective benchmarks in this unique case. **We urge CMS to carefully monitor the impact on 2021 data, and pending the results, reconsider a temporary exception to use performance year data to set 2021 quality measure benchmarks.**

ACP continues to oppose any increases to the weight of the Cost Category until [longstanding concerns about the validity and accuracy of existing cost measures are resolved](#). Specific concerns include attributing costs at the group practice level or higher, not attributing the same costs to multiple clinicians/groups, and risk adjusting for social determinants of health. ACP supports counting telehealth services toward the calculation of existing cost measures, but reiterates the importance of issuing appropriate guidance and making necessary changes to accommodate instances where the quality action cannot be completed during the telehealth and add-on telehealth modifiers for eQMs.

All measures should be held to transparent, consistent standards for statistical reliability, actionable impact on patient outcomes, and clinical evidence base. CMS' current average minimum reliability of 0.4 for episode-based cost measures is insufficient. Increasing case minimums improves measurement accuracy. While this may result in fewer clinicians being counted, this is preferable to clinicians having their payments adjusted based on measures of questionable validity. ACP [believes](#) measurement at the group practice or clinical team level is most appropriate for public reporting and payment purposes, while supporting the use of additional metrics for internal quality improvement efforts. Approval from an independent body such as the National Quality Forum should be mandatory, not optional, prior to finalizing any future MIPS measures. We also implore CMS to make MIPS measure development more transparent and user-friendly.

Over the past several years, ACP's Performance Measurement Committee (PMC) has [reviewed](#) hundreds of MIPS measures based on detailed evaluation criteria and found a good proportion to be invalid as currently designed. **ACP cannot support the inclusion of invalid measures, either in traditional MIPS or**

MVPs. That said, while ACP appreciates CMS' attempt to improve the accuracy of MIPS performance measurement by removing measures it identifies as having validity, accuracy, or clinical concerns, we are concerned that CMS' pace of measure removal may leave certain specialties with an insufficient number of measures to report. **We urge CMS whenever possible to make technical improvements to measures, as opposed to removing them.** In many cases, ACP's PMC offers specific suggestions to remediate technical issues with individual measures. We encourage CMS to review our [analyses](#) in detail and welcome opportunities to discuss our specific concerns.

While ACP supports reduced reporting burden on clinicians and does not oppose the use of administrative claims measures in concept, **the College has voiced several methodological concerns with administrative claims measures to date** that we would expect to be addressed before implementation, including a lack of actionability to meaningfully influence patient outcomes, particularly at the individual clinician level.

ACP strongly supports CMS finalizing a more gradual implementation for the registry testing requirement and delaying testing and data collection requirements, which ACP previously expressed concerns as being unduly burdensome, particularly now with all available resources being directed to combating the COVID-19 PHE.

ACP supports the finalized changes to the Promoting Interoperability Category, including a permanent 90-consecutive-day minimum reporting period and both optional measures. However, we have several technical concerns with both measures regarding their ability to apply to real-world practice settings that we recommend CMS address before making either mandatory in the future. We also reiterate our [past recommendations](#) to make broader changes to this category to encourage broader innovative uses of CEHRT and Health Information Technology by converting performance measures to yes/no attestations, similar to the Improvement Activities Category.

N. APM Performance Pathway (APP)

ACP supports the goals of the new APP to promote consistency across the QPP and offer flexible reporting options. However, we have serious concerns that requiring all clinicians to report the same six quality measures regardless of APM will inadvertently achieve the opposite effect and increase burden. ACP also has several technical concerns with the individual measures and does not support them in their current form, as explained in detail in our [comments](#) on the proposed rule.

O. Medicare Shared Savings Program (MSSP)

ACP urges CMS to freeze the mandatory "glidepath" to higher risk tracks through at least 2021 due to the ongoing PHE. As justification for not doing so in the final rule, CMS notes that nine percent of ACOs advanced in risk more quickly than required. ACP supports the option for ACOs to advance more quickly, but fewer than one in ten ACOs opting to advance to higher levels of risk does not justify forcing all ACOs to do so during a global pandemic. CMS shares in the rule that four ACOs terminated their participation on or before June 30, 2020, and approximately 35 additional ACOs have requested an end-of-year termination date. This is a major concern, and ACP fears not freezing the mandatory glidepath to higher risk tracks will result in even more ACOs dropping out of the program.

The College wishes to underscore the importance of making appropriate adjustments to future MSSP quality measure benchmarks, financial benchmarks, patient attribution, and risk adjustment

methodologies to account for the impact of COVID-19. This includes adjusting how performance years 2020 and 2021 will be weighted toward future financial benchmarks, and adjusting regional/national ratios to account for ACOs in COVID-19 “hot spots.” We disagree that a three percent decrease in assignable MSSP beneficiaries from 2019 is not substantial, and we urge CMS to adjust patient attribution calculations. We also urge CMS to remove or (at minimum) increase the current three percent cap on risk score increases over an ACO’s five-year participation agreement period, particularly in the wake of the COVID-19 PHE. We implore CMS to engage stakeholders and ACO participants in these discussions.

ACP appreciates CMS delaying several proposed changes, including increasing minimum reporting and data completeness requirements, and changes to the extreme and uncontrollable circumstances policy. **In particular, we appreciate CMS delaying by one year retirement of the Web Interface as a reporting option. We continue to have reservations about possible unintended consequences that may result from these policies,** including the impact on MIPS benchmarks for other MIPS reporters that would result from including ACOs and the substantial increase in minimum data requirements for ACOs. ACP strongly supports CMS reversing its proposals to terminate the pay-for-performance phase-in period for new ACOs but opposes the Agency’s decision to finalizing the pay-for-performance phase-in for new measures, which we believe provides ACOs with an important opportunity to familiarize themselves with new measures before payments are impacted. We look forward to continuing to work with the Agency over the next year to mediate these unintended consequences.

P. Medicare Diabetes Prevention Program (MDPP)

The College strongly supports several finalized flexibilities and believes that many, including offering services via telehealth, could help to expand patient access, particularly for those that face transportation or mobility issues, and improve the overall success of the program. We encourage CMS to consider making many of these flexibilities available on a permanent basis.

Q. Advanced Alternative Payment Models (APMs)

ACP appreciates [model-specific flexibilities](#) CMS previously finalized for several APMs and supports newly finalized policies not to reconsider a model’s status as an Advanced APM or revoke QP status from any ECs due to model changes made in direct response to COVID-19. However, **the College continues to feel strongly that broader protections for Advanced APM participants are warranted,** similar to those finalized for MIPS. Advanced APM participants should be held harmless from financial losses or penalties for the 2021 performance year. Additionally, 2020 and 2021 performance data should not adversely impact shared savings or other model payments, as practices are still very much entrenched in battling the PHE and face a long recovery. CMS will also need to consider the lasting effect of the PHE on future performance measure benchmarks, financial benchmarks, patient attribution, risk adjustment, and other programmatic methodologies.

COVID-19 has [exacerbated](#) the underlying issues with the fee-for-service (FFS) payment system. Many physician practices are [hungrier](#) for FFS alternatives than ever, particularly models with predictable, prospective payments. Practices in APMs were [better equipped](#) to operationalize a more rapid pandemic response and in many cases, better able to weather it financially. **CMS should be working to introduce new Advanced APMs to meet the anticipated increased demand for FFS alternatives due to COVID-19.** ACP appreciates CMS’ recent finalization of several new models, including the Primary Care

First Model, Community Health Access and Rural Transformation (CHART), and Direct Contracting Models. We encourage CMS to maintain this pace, with an emphasis on models that would address outstanding needs, including specialty-focused and multi-payer models. ACP implores HHS to prioritize ACP's [Medical Neighborhood Model](#), which was recently [recommended](#) by the PTAC (Physician-Focused Payment Model Technical Advisory Committee) for pilot testing. We welcome an opportunity to further discuss our model and help ready it for testing or implementation.

ACP continues to strongly oppose CMS' new approach for distributing Advanced APM incentive payments that prioritizes payment year TINs. Doing so minimizes the clinical care team model and moves further from actions completed during the performance year. ACP urges instead for CMS to make incentive payments earlier in the payment year, which lessens the window for NPI-TIN changes to occur. The College also strongly objects to CMS' proposed 60-day cutoff for claiming incentive payments. As an alternative, we recommend the date Advanced APM payments for the subsequent year are announced.

ACP greatly appreciates CMS finalizing a new targeted review process for QP determinations, which ACP has long advocated for. However, the College remains concerned that the scope is too limited.

III. Conclusion:

Thank you for this opportunity to comment on CMS' notice of proposed rulemaking regarding changes to the Physician Fee Schedule, Quality Payment Program, and other federal programs for Calendar Year 2021 and beyond. We are confident these recommended changes would improve the strength of these proposals and help promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We appreciate the opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine. Please contact Brian Outland, Director, Regulatory Affairs for the American College of Physicians, at boutland@acponline.org or 202-261-4544 with comments or questions about the content of this letter.

Sincerely,



Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians