COGNITIVE CARE ALLIANCE

September 6, 2022

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov

RE: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-P)

Dear Administrator Brooks-LaSure:

The Cognitive Care Alliance (CCA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2023. The CCA members represent physicians from cognitive specialty societies who are familiar with the day-to-day management of the chronic conditions that affect Medicare beneficiaries. We share a commitment to ensure that the valuations of physician services within the MPFS are accurate, reliable, evidence-based, and accountable to deliver the best outcomes for all Medicare beneficiaries and a balanced physician workforce. Specifically, our comments will focus on the following issues in the proposed rule:

- Evaluation and Management (E/M) Services
- Payment for Medicare Telehealth Services
- Strategies for Improving Global Surgical Package Valuation

Evaluation and Management Services

The CCA applauds the multiyear effort by CMS to ensure accurate and reliable relativity within the MPFS. As originally conceived, Medicare services were to be priced relative to one another based on work intensity. William Hsiao's model included four aspects of work that would contribute to work intensity, time for service delivery, mental effort, technical skill, and stress.[1]

As the agency aptly points out, the practice of medicine is ever changing with new interventions, improved technologies, and more efficient workflows. Balancing the delivery of

[1] Hsiao WC, Yntema DB, Braun P et al: Measurement and Analysis of Interservice Work: JAMA 1988;260:2361-2370

these care innovations with the growing and aging Medicare beneficiary population creates a challenging dynamic for CMS. The CCA is supportive of the agency's efforts to continually address distortions in the relativity, and ultimately the pricing, of services. The practice of medicine has changed over the last 50 years and the vast array of interventions, both procedural and pharmacologic, has dramatically expanded. However, we would point out that the expansion in the non-procedural options for care have been significant, while the coding structure has not evolved to the same extent. The advent of the biologics and gene therapies add enormous complexity to the work of the members of the CCA societies as well as a vast range of other specialties.

The CCA appreciates that CMS is proposing to adopt nearly all the revisions for CPT® codes used to report the inpatient evaluation and management (E/M) code families including the code descriptors and documentation guidelines, mirroring those previously made to the outpatient E/M services. These improved documentation expectations provide consistency across E/M code families and reduce administrative burden. We recognize the significant effort this entailed, and the resulting improvements will continue to benefit CCA members who primarily bill for E/M services.

While we appreciate CMS' efforts, the CCA remains concerned that the values of the E/M services continue to be inaccurate despite the recent revaluation. We recognize that CMS has proposed to adopt the Relative Value Scale Update Committee (RUC) recommended values for the inpatient and other E/M families being considered in this rulemaking cycle; however, based on the RUC's input, CMS is proposing to reduce the value of some of the inpatient services despite the complexity of this work that has not diminished, and when finalized, certain inpatient services will be valued less than the comparable outpatient service. For example, CPT code 99205, the highest level new outpatient service code, and CPT code 99223, the highest level initial hospital care code, are valued at 5.39 RVUs and 5.19 RVUs respectively in the facility setting. Inpatient care is more complex and expensive than outpatient care as the services that require hospital admission are more likely due to an unstable condition that must be addressed immediately; the amount of data collected and assessed in a short period is considerable; the interventions employed frequently carry higher risk; and there are many more concurrent interactions among treating staff.

In the proposed rule, CMS states, "To the extent we are proposing to adopt the RUC-In recommended values for Other E/M visits beginning for CY 2023, we do not agree with the RUC that the current visit payment structure among and between care settings fully accounts for the complexity of certain kinds of visits, especially for those in the office setting, nor do they fully reflect appropriate relative values, since separate payment is not yet made for G2211."[2] The CCA agrees with CMS that this work is not properly valued and will continue to be as conversion factor decreases erode the value of all physician services.

[2] https://public-inspection.federalregister.gov/2022-14562.pdf?1657224928

To appropriately value E/M work, the CCA proposes the establishment of an expert panel to serve in an advisory capacity to CMS. We believe an expert panel can serve an important role in ensuring MPFS services are appropriately valued using the best available data to reflect the complexity of care delivered. An expert panel, providing an independent assessment of available data and recommendations to CMS, will stabilize what has evolved to become an irregular process and help maintain an appropriate balance in the MPFS which may also have the added benefit of improving access to a well-trained cognitive workforce.

The expert panel would be empowered to collect its own survey data and could work closely with the RUC in doing so. Importantly, survey data collection would necessarily become more representative since current RUC surveys, in many cases, are not broadly representative. Given the central role of the MPFS in the pricing of all health care professional services, having an accountable and transparent process that is evidence based is long overdue.

CCA members envision a panel charged with developing recommendations on how to appropriately define, document, and value E/M services. We maintain that CMS must utilize the best data, metrics, and analytic tools for the determination of relative valuations within the Resource Based Relative Value Scale and ensure that physician services are accurately valued on a more regular basis. We have included our expert panel proposal at the end of these comments for your convenience.

Payment for Medicare Telehealth Services

The telehealth flexibilities implemented by CMS during the COVID-19 public health emergency (PHE) have been invaluable to patients. To the extent the agency has the statutory authority, the CCA urges CMS to continue to ensure that physicians will continue to be able to provide virtual services so that Medicare beneficiaries may retain access to medically appropriate telehealth services.

The CCA appreciates that CMS began outlining its plans to implement the 151-day extension of certain telehealth services once the PHE concludes. The agency proposed to allow all services that were added to the telehealth list on a temporary basis during the PHE to remain available for 151 days after the conclusion of the PHE. The CCA supports all efforts to develop and implement evidence-based reimbursement policy and the virtual delivery of these services for additional time will provide for the collection of additional telehealth utilization data which may be used to develop future evidence-based policies including those regarding the Medicare telehealth services list. Additionally, the CCA urges CMS to finalize its proposal to add additional services to the Medicare telehealth list with a Category 3 designation, including the new HCPCS codes for prolonged services, HCPCS codes GXXX1, GXXX2, and GXXX3.

Furthermore, CMS restates established policy that telehealth services will be paid at the facility payment rate after the PHE concludes as the agency believes this best reflects the direct and indirect practice expenses of telehealth services. The CCA respectfully disagrees with this policy

and urges CMS to reimburse telehealth services at the physician office rate to account for the significant time and resources that are commensurate with those of an in-person visit. The CCA believes that parity for telehealth services is necessary to prevent disparities in access and protect quality of care for underserved communities.

Moreover, we recognize that the telephone E/M codes were not added to the telehealth list on a Category 3 basis because the agency defines telehealth services as having a simultaneous audio/video connection and does not view these services as equivalent to those delivered face-to-face. The CCA urges CMS to continue working with Congress to ensure that CMS has the authority to cover telephone E/M services after the PHE concludes. Not only is it important for these services to be covered, but they must be reimbursed adequately. The CCA cautions that decreasing reimbursement for these services undervalues the physician work involved and will present a significant barrier to access to care for beneficiaries without video or broadband access.

Lastly, the CCA believes that the evolution of telehealth service codes illustrates an area where the establishment of an expert panel may be beneficial by providing the ideal clearinghouse for the new and emerging data on telehealth services. Furthermore, the expert panel could advise CMS around the most critical issues including appropriate valuations for telehealth services and ways to minimize fraud and abuse, which the agency and Congress has been working to address. To ensure that telehealth policy is implemented in a way that best serves Medicare beneficiaries, the CCA again recommends CMS establish an expert panel and would welcome the opportunity to work with the agency to establish this mechanism.

Strategies for Improving Global Surgical Package Valuation

We appreciate that CMS is seeking input on strategies to improve the accuracy of payment for the global surgical packages and make sure they are appropriately valued. We recognize that the effect of modifying the global surgical payments will ripple through the entire MPFS. The CCA's commitment is to an evidence-based data driven approach to valuing physician services. As CMS considers new methods to achieve this, we believe all data collection for services with global payments must be done in an evidence-based manner.

Thank you for the opportunity to provide these comments. If you have any questions or require additional information, please contact Michaela Hollis at mhollis@dc-crd.com.

Most sincerely,

John Goodson, MD
Chair

Cognitive Care Alliance Member Organizations:

American Society of Hematology
Infectious Diseases Society of America
Society of General Internal Medicine

Proposal to Form an Expert Panel to Review Evaluation and Management Services

Request:

The Cognitive Care Alliance (CCA), representing physicians from cognitively focused specialty societies, proposes that the Centers for Medicare & Medicaid Services (CMS) convene an expert panel to develop recommendations on how to appropriately define, document, and value evaluation and management (E/M) services.

Background/ Statement of Need:

The CCA thanks CMS for finalizing significant changes to the outpatient E/M services in the CY 2020 Medicare Physician Fee Schedule (MPFS) that will become effective January 1, 2021. We believe these changes are an important first step to appropriately value cognitive work and should be implemented as finalized. The deficiencies in the E/M coding structure and values have resulted in cognitive workforce shortages and limited Medicare beneficiary access to certain primary care and cognitive services. The principal architect of the Resource-Based Relative Value Scale (RBRVS), Dr. William Hsiao from Harvard University, clearly stated that the development of the E/M portion of the MPFS was not adequately supported and that more refinement was needed.[3]

Changes to the outpatient E/M services are being implemented at a time when the practice of medicine looks significantly different than it did when the RBRVS was established. Now CMS spends approximately $100 billion on MPFS services. Forty percent of that spending is on E/M services - the outpatient E/M services account for 27 percent of MPFS spending. Since the late 1980s, the methodologies of health services research have evolved, the principles of representative databases have been firmly established, methods of adjustment to reflect the influences of health, social, economic, geographic and other factors are more robust, and the unintended consequences of the existing pricing mechanisms have become more clear.[4] All of these factors provide CMS with new tools to value cognitive work.

CMS' revisions to the outpatient E/M services have been lauded by the member societies of the CCA and by most of the medical community, yet our societies continue to express concern that these changes do not address the legacy mis-valuation of E/M services. Most importantly, the agency must sustain its commitment to fully understand the resources and work required to deliver cognitive E/M services in both outpatient and inpatient settings, including the expertise demanded to manage the "complexity

[3] Hsiao, WC, Braun, P, Dunn DL et al. Med Care 1992;30 (11) Supplement: NS1-NS12.
[4] Goodson JD. Unintended consequences of resource-based relative value scale reimbursement. JAMA. 2007; 298(19): 2308-10.

density" of each encounter, and to accurately define and value service codes that capture current medical practice.

The CCA has called on CMS to conduct research to better understand the components, inputs, interactions, outputs, and implications for all E/M services. We propose that CMS create an expert panel with the express purpose of establishing a permanent mechanism to ensure that the relative valuation of physician services is data driven and reflects the current practices of medicine to achieve the best possible outcomes for all Medicare beneficiaries. Again, this panel would not delay or change the E/M payment reforms finalized in the CY 2020 MPFS. Rather, this panel would assist CMS to ensure that cognitive work is accurately defined and valued under the MPFS.

Proposed Panel Charge, Responsibilities and Composition:

Charge

Using an evidence-based approach, the panel will assess the current definitions, documentation expectations and valuations of existing E/M services and develop a set of recommended changes to address identified data gaps and/or inadequacies.

Responsibilities

- ***Evaluate and summarize*** the current data and research related to E/M services.
- ***Review*** the current methodologies and procedures used to define and value services under the MPFS.
- ***Identify*** the specific knowledge gaps including parameters for additional data needs and research required to study key topics and answer key questions, including:
    - Does the existing E/M code set adequately define and describe the full range of E/M services?
    - If adequate, are the current values for E/M services appropriate? Are the gradations of valuation aligned with the gradations of service intensity?
        - Do they appropriately account for all input elements that contribute to the intensity of work valuation, including the development and maintenance of cognitive expertise, the complexity of the clinically relevant interactions among individual patient characteristics, diagnoses and therapeutics, and the risks and implications that arise from different levels of encounter intensity?
        - Are the existing code definitions clear and accurate? If so, then code definitions should be reviewed to ensure linkage to definable auditing metrics.
    - If inadequate, what changes to the E/M service codes or additional codes are needed to address the possible deficiencies noted above?
    - Collaborate with the Office of the National Coordinator for Health Information Technology (HIT) to ensure that documentation requirements are easily integrated in the electronic health record (EHR).

- Consider and research the development of guidelines for the future relative valuation of physician services. Propose a process whereby CMS can ensure that the MPFS is based on accurate and updated service code definitions, including service code times, and a reliable process of relative valuation based on data collected from patients, physicians, enterprises, and institutions.

    - Assess the utility of data describing E/M services from current resources, including the National Ambulatory Medical Care Survey (NAMCS), the Medical Expenditure Panel Survey (MEPS), de-identified Medicare payment data, and de-identified electronic health record data sources.

- ***Develop*** new valuation concepts, if warranted, to capture the breadth and value of E/M services and determine how these can be best integrated in with existing RBRVS.
- ***Recommend*** changes, if warranted, that should be made to the current E/M code set to ensure the valuations of these codes reflect current medical practice.
- ***Oversee the development of and provide input for*** any new E/M services including:
    - service descriptions,
    - billing and coding guidelines, and
    - program integrity requirements

Panel Composition

To ensure diverse perspectives are factored into the development and refinement of E/M services, membership should include:

- Clinicians, such as general practice and specialty medicine physicians, and other qualified health professionals;
- Medicare Beneficiaries;
- Health economists and health services researchers.
- Experts in medical coding and code valuation;
- Health informatics experts;
- Experts in program integrity and compliance;
- Stakeholders with expertise in Medicare payment policy.

Cognitive Care Alliance Member Organizations:

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