



October 5, 2020

The Honorable Seema Verma,
Administrator Centers for Medicare & Medicaid
Services Department of Health and Human Services
P.O. Box 8013 Baltimore, MD 21244-1850

RE: CMS – 1734-P Medicare Program: CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Payment for Office/Outpatient Evaluation and Management Services. (Vol. 85, No. 159), August 17, 2020

Dear Administrator Verma:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care working to change the fundamental economic incentives and design of the health care system. Our goal is to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone. *Consumers First* appreciates the opportunity to provide comments on the Medicare Physician Fee Schedule proposed rule for Calendar Year 2021.

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

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

Given our focus on transforming health care payment and delivery systems to provide high value care to consumers, our comments focus on the following sections of the proposed rule:

- Medicare Telehealth and Other Services Involving Communications Technology
- Payment for Office/Outpatient Evaluation and Management (E/M) and Analogous Visits
- Immunization Services

Medicare Telehealth and Other Services Involving Communications Technology

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

Under the proposed rule, CMS is proposing: 1) to add the Healthcare Common Procedure Coding System (HCPCS) codes for 22 services to the list of telehealth services that Medicare covers. CMS is proposing to add some of those services to the Medicare telehealth list on a Category 1 basis; and 2) to create and add a temporary third category of services to the Medicare telehealth services list. Category 3 services reflect services that the Administration added to the Medicare telehealth list under the public health emergency. Those services would remain on the Medicare telehealth services list through the end of the year in which the PHE ends.

Consumers First is supportive of the addition of a third category of telehealth services to the Medicare telehealth list through the end of the year in which the PHE ends. *Consumers First* is also supportive of ensuring that audio-visual, audio-only services and remote monitoring services are available for our nation's families for the duration of the public health emergency and beyond.

Consumers First also believes that this is a critical moment for our nation to grapple with how to effectively and sustainably integrate high value telehealth into our health care payment and delivery system. While we support expanded access to telehealth and the establishment of a permanent and sustainable payment system to support the integration of telehealth into health care delivery, we are concerned by the significant limitations of relying on fee-for-service payment to achieve that goal.

It is well established that the financial incentives within fee-for-service (FFS) payment lead to an increase in the volume of services provided within the health care system, which in turn drives up health care spending without any relationship to the quality of care. FFS health care is a significant driver of the poor health outcomes our nation's Medicare beneficiaries and others¹, and the billions of dollars of health care waste in our system.² It is a major contributor to health care costs continuing to rise and fewer families being able to afford health care. Plainly stated, FFS health care often creates a conflict with the fundamental responsibility of the health care system to ensure the health of all families in our nation. The dynamics of FFS were amplified by the COVID-19 pandemic which sent shockwaves through our health care system and forced many health care providers to rearrange staffing, modify facilities, rely heavily on telehealth and community-based care, and reimagine the best way to support patients – all while facing significant and persistent revenue shortfalls. At a time when people needed health care the most, FFS payments left our physician practices and the patients they serve in a precarious and untenable position.

¹ Stuart Guterman, "Wielding the Carrot and the Stick. How to Move the U.S. Health Care System Away from Fee-for-Service Payment," August 27, 2013, Available at: <https://www.commonwealthfund.org/blog/2013/wielding-carrot-and-stick-how-move-us-health-care-system-away-fee-service-payment>.

² Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

Some physician practices, particularly within primary care, have seen declines of up to 50% in service volume.³

Consumers First agrees that building telehealth into the Medicare Physician Fee Schedule has been an effective way to both bolster access to care for patients and get financial relief into the hands of providers during the public health emergency so they can continue providing critical health care for our nation's families. Importantly, because the cost of telehealth services are less than the cost of in-person visits,⁴ we are concerned that an across-the-board extension of telehealth payment parity beyond the PHE that is reliant on the fee-for-service payment model will only incentivize providers to continue to drive the volume of visits regardless of the costs to the system and value to patients. We therefore urge CMS to reassess the long-term approach to telehealth payment in the 2021 Medicare Physician Fee Schedule in anticipation that the PHE will end next year.

Further, we are concerned that the proposed rule does not provide sufficient guidance for health care providers on how to provide high quality, high value telehealth health visits on a permanent basis. Without clearly defined guardrails to ensure the provision of high value telehealth services, *Consumers First* believes that there is significant risk that fee-for-service telehealth services will further fragment care, generate increased volume and ultimately could result in increased costs for the Medicare program, while having negligible or negative impact on the quality of those services and the health of Medicare beneficiaries.

***Consumers First* recommends the following:**

- **CMS should promulgate a regulation to ensure all telehealth visits meet quality standards and serve the needs of Medicare beneficiaries.**
- **Rather than building telehealth on fee-for-service financial incentives through the Medicare Physician Fee Schedule, CMS should integrate telehealth into existing alternative payment models that utilize prospective, capitated payments. By design, alternative payment models shift economic incentives so that payment to providers is based on clinical judgment and improving patients' health, not churning on fee-for-service payment, which drives up volume and in turn increases Medicare spending and costs for Medicare beneficiaries. Examples of alternative payment models that could immediately integrate telehealth include Comprehensive Primary Care Plus, Track 2 and Primary Care First.**

Further the advancement and utilization of telehealth to improve access to high-value health care in rural communities is a substantial strategy in improving rural economic development, including developing a robust infrastructure, with access to broadband and computer systems, to support the provision of telehealth services in these communities. Federal resources to support this infrastructure are housed across many different federal agencies and departments, and various federal agencies are currently working in their silos to address rural economic development. Improving the health of our nation's rural communities, therefore, requires a coordinated, multisector federal strategy and financial investment.

³ Ateev Mehrotra, Michael Chernew, David Linetsky, Hilary Hatch, David Cutler. "The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges." May 19, 2020. Available at: <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>

⁴ Ashwood JS, Mehrotra A, Cowling D, Uscher-Pines. Direct-to-consumer telehealth may increase access to care but does not decrease spending. *Health Affairs* 2017; 36(3):485-491. doi:10.1377/hlthaff.2016.1130
Ashwood, Mehrotra, Cowling, and Uscher-Pines, *Health Affairs* March 2017, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1130>

Consumers First recommends HHS establish a multi-agency Federal Rural Health Telehealth Task Force to develop a coordinated national strategy to address rural tele-health needs across the country.

Payment for Office/Outpatient Evaluation and Management (E/M) and Analogous Visits

Central to improving the health and health care of our nation’s families is ensuring that primary care providers are valued and empowered in our health care delivery system.⁵ For decades, procedural services have been reimbursed through Medicare at much higher levels than cognitive services, which comprise the bulk of primary care.⁶ This payment is mirrored by commercial health insurance and Medicaid, which often bases payment levels off Medicare payment rates. Unlike many procedures, Evaluation and Management (E/M) services are composed of activities that require the clinician’s time, such as taking patient’s history, examining the patient and engaging in medical decision-making – services that cannot be easily replaced or optimized by advances in technique or technology. Recognizing the need to reevaluate E/M codes, in 2019, over fifty medical specialty societies surveyed their members regarding the relative value of E/M visits and those findings resulted in the American Medical Association Relative Value Scale Update Committee (RUC) recommending to CMS an increase to the Relative Value Units (RVUs) for E/M services. As a result of the historically lower reimbursement for primary care, today there is a much smaller percentage of primary care providers in our nation, and access to primary care for many families is becoming a significant challenge.⁷ Moreover, much of the waste in our health care system is anchored in high-cost specialty care.⁸ To address this profound concern, it is critical that CMS reconfigure the Medicare Physician Fee Schedule to appropriately revalue primary and specialty care to correct the historical payment distortions.

CMS is proposing to raise the values of nine E/M codes, referred to as office visits, by increasing the value of the physician work relative value unit (RVU). The Medicare Physician Fee Schedule utilizes the Resource-Based Relative Value Scale (RBRVS), which is derived from a hypothetical “relative value” of the service provided. By statute, the relative value of each coded service is calculated based on three components: amount of physician work; practice expenses; and liability expenses. Once the relative value unit for each service is calculated, it is multiplied by a conversion factor that adjusts for geographic variation, to arrive at a dollar amount, or fee, for each service. By increasing the work RVU for these nine E/M codes, CMS must reduce the work RVU of other codes to ensure the Medicare Physician Fee Schedule is budget neutral as required under federal statute. This revaluation of work RVU will result in long overdue increases in E/M services for a range of specialties. The adoption of these changes will increase payment for primary care specialties as well as other specialties dependent on office visits including general practice physicians, family practice physicians, rheumatologists and nurse practitioners.

⁵ The Commonwealth Fund, Primary Care – Our First Line of Defense, June 12, 2013, Available at: <https://www.commonwealthfund.org/publications/other-publication/2013/jun/primary-care-our-first-line-defense>.

⁶ Bruce Steinwald, Paul B. Ginsburg, Caitlin Brandty, et al. “We need more primary care physicians: Here’s why and how.” USC-Brookings Schaffer on Health Policy, July 8,2019, Available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/08/we-need-more-primary-care-physicians-heres-why-and-how/>

⁷ Medicare Advisory Payment Commission. Issues in Medicare Beneficiaries Access to Primary Care. Report to Congress, June 2019, Available at: http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf

⁸ Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

It also increases payment rates for bundled payments for emergency department care, end-stage renal disease and maternal care.

Overall, CMS is proposing to increase the work RVU by 28% for established patient office visits and 8% for new patient office visits. These are significant increases. *Consumers First strongly supports increasing the work RVUs for E/M codes thereby increasing payments for primary care providers and general practitioners.* Evaluation & Management visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E/M visits are essential for a high-quality, coordinated health care delivery system. While the E/M changes still do not fully capture the resource costs involved in furnishing high-value primary care, they will help to correct the current Medicare payment distortion which—over the long run—will increase the pipeline of primary care physicians and improve beneficiaries' access to primary care services.

Immunization Services

Central to improving the health and well-being of the nation's children, adults and the overall health of the population is ensuring affordable access to vaccinations. A critical step in safeguarding access to vaccinations is ensuring that providers, including pediatricians, are reimbursed adequately for administering vaccination to children and adults. CMS bases the value of Current Procedural Terminology (CPT) codes for immunizations administration on the Medicaid Physician Fee Schedule. Commonly used codes in pediatric and adult care are for immunization administration (IA), and these are used by pediatricians, family physicians, and other frontline clinicians for vaccine administration and reimbursement. In 2010, CMS linked these IA codes to separate codes for therapeutic injections in adults. Then, in 2018, CMS reduced the value of the therapeutic injection code by more than 50 percent, thereby significantly cutting reimbursement to pediatricians and other health care providers who administer vaccinations to children and adults. While CMS implemented policy to maintain payment for IA codes for Medicare-specific vaccines, IA codes – which are widely used for pediatric and adult populations outside the Medicare program – were excluded from CMS's policy change. Medicaid and private payers rely on the Medicare Physician Fee Schedule to set their rates, and these payment cuts have significantly impacted clinicians that administer vaccines to children.

Under this proposed rule, CMS proposes to eliminate linking IA codes to therapeutic injections, which would increase the relative value units (RVUs) for immunization administration codes, resulting in increased payment rates for providers administering vaccinations to children and adults. *Consumers First supports CMS's proposal to unlink IA codes from therapeutic injections, which will result in more appropriate codes and RVUs for vaccine administration, thereby increasing accessibility and affordability of vaccines for providers and patients.* This proposed change underscores the important role of immunizations in securing the health of our population by preventing community outbreaks of vaccine-preventable illness, and it ensures more equitable access to vaccinations.

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

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County and Municipal Employees
American Federation of Teachers
Families USA
First Focus on Children
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