September 13, 2021

Chiquita Brooks La-Sure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBJECT: CMS-1751-P, Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements; Proposed Rule; Federal Register (Vol. 86, No.139), July 23, 2021

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including numerous home health agencies (HHAs), the California Hospital Association (CHA) is pleased to submit comments on the calendar year (CY) 2022 physician fee schedule (PFS) proposed rule. CHA provides comments on several provisions of the proposed rule that are significant to hospitals and the physicians who provide care in our member hospitals.

In summary, CHA:

- Urges CMS to work with Congress to address significant payment reductions to the proposed conversion factor and physician payments.
- Urges CMS to continue to support the expansion of telehealth by finalizing proposals to maintain Category 3 telehealth services until the end of CY 2023 and adopt the same policy for telehealth services added to the Medicare telehealth list for the duration of the COVID-19 public health emergency (PHE), but not as Category 3 services.
- Strongly supports waiving geographic site restrictions and adding the patient's home as an originating site for mental health services provided via telehealth. We urge CMS to consider revising its proposed policies on the interval of required in-person visits and clarify that patients can be seen in-person by clinicians in the same group as the practitioner who provides the telehealth service.
- Strongly supports CMS' proposed modification to the definition of "interactive telecommunications system" to include audio-only communications for mental health services

and urges CMS to apply this definition to additional services, such as evaluation and management (E&M) services as allowed during the COVID-19 PHE.
- Strongly supports a delay in the payment penalty phase of the Appropriate Use Criteria (AUC) program and urges CMS to reconsider proposals to repurposes certain modifiers.
- Urges CMS to reconsider several proposals related to E&M services, including proposals related to split billing and critical care services.
- Urges CMS to clarify several proposals related to the Rural Health Clinic (RHC) per visit limit as established by the Consolidated Appropriations Act of 2021 (CAA) and provide additional flexibilities for provider-based RHCs that were under development prior to the passage of the CAA.
- Generally supports proposed changes to the Medicare Shared Savings Program (MSSP). We appreciate CMS' delay of changes to quality reporting and provide feedback in response to the agency's requests for information related to benchmarking and risk adjustment in the MSSP.

Physician Fee Schedule Conversion Factor

The proposed conversion factor for CY 2022 is $33.5848. This reflects the expiration of the 3.75% increase for services furnished in 2021, which was included in the CAA, the 0% update adjustment factor specified under section 1848(d)(19) of the Act, and a budget neutrality adjustment of -0.14%. CHA notes the proposed conversion factor is decreased from the CY 2021 conversion factor of $34.8931.

CHA is deeply concerned that this reduction in physician payments will reduce access to care not just for Medicare beneficiaries, but all residents in California. Prior to the pandemic, many physicians were already struggling financially due to updates to the conversion factor that failed to keep up with the cost of running a practice. Many of these costs are a direct result of increased regulatory requirements and administrative burden. CHA notes the proposed physician practice conversion factor in 1994 ($32.90) when properly adjusted for inflation using the Consumer Price Index would be worth $60.23 in today's dollars[1]. This implies that if finalized as proposed, the conversion factor over the last 27 years has lost 44% of its purchasing power. And the ongoing pandemic has only exacerbated and accelerated this pressure, as it continues to increase practice expenses related to personal protective equipment (PPE) and staffing, while causing patients to avoid receiving medically necessary care. A recent survey by the California Health Care Foundation finds that 28% of California's hospitals continue to experience financial instability as a result of the pandemic[2]. **CHA asks CMS not to exacerbate this further by working with Congress to eliminate the 3.75% payment reduction to the conversion factor.**

Telehealth and Other Services Involving Communications Technology

During the COVID-19 PHE, telehealth and other virtual care services have been a critical component of maintaining access to care while mitigating the spread of COVID-19. As patients and clinicians have become more comfortable using these services, it is clear telehealth will continue to be an important method to improve access to care and reduce barriers for some of our most vulnerable populations — including to address health disparities experienced by people of color, as well as those living in rural and underserved communities.

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[1] https://www.bls.gov/data/inflation_calculator.htm
[2] https://www.chcf.org/wp-content/uploads/2021/05/COVID19ProviderSurveyViewsFrontLines03282021.pdf

The regulatory flexibilities provided during the COVID-19 PHE have allowed hospitals to operationalize telehealth and other virtual services not as simply a replacement for in-person care, but as a new tool for improving care delivery. We appreciate that, in the proposed rule, CMS continues to support increased coverage and payment for telehealth services and offer comments on specific proposals below. **However, we continue to urge the agency to work with Congress to remove statutory barriers to the greater adoption of telehealth. In particular, CHA supports the elimination of geographic and originating site restrictions that so often limit telehealth services to rural patients and do not recognize the patient's home as a suitable location to receive these services.**

In addition, we urge CMS to ensure telehealth services are adequately reimbursed at levels that recognize their important place in the care delivery system. Telehealth services require significant investments in technology, as well as the time and expertise of clinicians providing the services. Hospitals do not view telehealth as a replacement for in-person care and must invest significant resources to maintain the infrastructure to provide that care. CMS should ensure that telehealth and other communication technology-based services provide reimbursement equitable to in-person care.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
In the CY 2021 PFS final rule, CMS created a third category for adding services to the Medicare telehealth list, Category 3. This new category describes services that were added to the Medicare telehealth services list during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not sufficient evidence available to consider adding the services under the existing Category 1 or Category 2 criteria. As previously finalized, the services added under Category 3 will remain on the Medicare telehealth services list through the calendar year in which the PHE ends and then must meet the Category 1 or 2 criteria to be added on a permanent basis.

CMS acknowledges there is significant uncertainty of when the PHE will end and notes the impact of this uncertainty on Category 3 services, including that these services could be removed from the list before stakeholders have had time to compile and submit evidence to support their permanent addition on a Category 1 or Category 2 basis. In response, CMS proposes to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.

CHA strongly supports CMS' proposal to retain Category 3 services on the Medicare telehealth list through the end of CY 2023. This proposal will ensure that hospitals and clinicians have sufficient time to update their workflow to reflect the availability of Medicare telehealth services, while also providing additional time to submit evidence to support permanent additions to the telehealth list. In addition, we urge CMS to also retain the services — as listed in Table 11 of the proposed rule — that have been added to the Medicare telehealth list for the duration of the PHE, but not extended on a temporary Category 3 basis in the CY 2021 PFS final rule until the end of CY 2023. Absent such a policy, these services would be ineligible for Medicare coverage and payment at the end of the declared PHE, creating a cliff that could disrupt hospital operations that have come to rely on the use of telehealth to care for patients since early 2020.

Telehealth Services for Diagnosis, Evaluation, or Treatment of Mental Health Disorder
The CAA waived existing geographic restrictions under Section 1834(m) of the Social Security Act and added the patient's home as a permissible originating site for telehealth services provided for the purpose

of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the COVID-19 PHE. The CAA requires that the provider furnishing a telehealth service must furnish an initial in-person service within six months prior to the telehealth service and thereafter at such times the Secretary of Health and Human Services determines appropriate. CMS proposes to implement this provision by requiring providers to conduct an in-person, non-telehealth service within six months prior to providing an initial mental health telehealth service, and at least once every six months thereafter.

CHA strongly supports this expansion of telehealth for patients receiving mental health services. The COVID-19 PHE has demonstrated the effectiveness of telehealth in the treatment of mental health disorders. Following a sudden surge in telehealth visits upon the onset of the COVID-19 PHE, telehealth visits have continued to level off at much higher rates than prior to the pandemic, as patients have gained experience and comfort with receiving their care through these modalities. In addition, several studies — including patient surveys and claims analysis — have shown that mental health services have seen the largest increase in telehealth utilization. The expansion of Medicare telehealth services under the CAA will ensure that patients maintain access to these services beyond the PHE.

However, we are concerned that CMS' proposal to require an in-person visit every six months will serve as a barrier to access to care for these patients. Our members report that telehealth has allowed them to reach patients who were previously unable to access care due to behavioral health professional shortages, transportation challenges, and even stigma associated with seeking help. A requirement for an in-person visit every six months is likely to significantly challenge this population. Notably, there is no corresponding in-person visit requirement for patients receiving telehealth services furnished for treatment of a diagnosed substance use disorder or co-occurring mental health disorder. **We urge CMS to consider a longer time frame for subsequent in-person visits beyond the statutorily required visit within six months of the initial telehealth encounter. We also urge CMS to specify that subsequent in-person visits can be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service.**

Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology
Under current law, telehealth services must be furnished via a "telecommunications system." In existing regulation, CMS defines this to mean "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner." In the proposed rule, CMS proposes to amend its regulations to define "interactive telecommunications system" to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home. In addition, CMS proposes to limit payment for audio-only mental health services to physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.

CHA strongly supports CMS' proposed modification to the definition of "interactive telecommunications system" to include audio-only communications for mental health services.

During the COVID-19 PHE, CMS waived the requirement that telehealth services be delivered with video technology to allow the provision of certain behavioral health, counseling, and E&M services via audio-only communication. CHA members have appreciated these flexibilities as it has allowed them to reach patients who do not have access to, or are uncomfortable with, video technology. We agree that this proposal will greatly expand access to mental health services and appreciate that CMS recognizes that a sudden discontinuation of audio-only flexibilities at the end of the PHE could negatively impact access to care. **We urge CMS to further broaden its proposal to include payment for additional audio-only telehealth services, such as for E&M services as allowed during the COVID-19 PHE.**

Expiration of PHE Flexibilities for Direct Supervision Requirements
During the COVID-19 PHE, CMS revised the definition of "direct supervision" to allow the supervising professional to be immediately available through a virtual presence using real-time audio/video technology for the direct supervision of diagnostic tests, physicians' services, and some hospital outpatient services. Under the CY 2021 PFS final rule, this policy would end at the end of the calendar year in which the PHE ends or December 31, 2021, whichever is later. **The policy, which is subject to the clinical judgment of the supervising physician and non-physician practitioner, has been proven a safe and effective option for the provision of direct supervision for the duration of the PHE. CHA urges CMS to extend this policy permanently.**

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

As required by the Protecting Access to Medicare Act (PAMA) of 2014, CMS continues to implement a program to promote the use of AUC for advanced diagnostic imaging services. Under the program, payment to the furnishing professional for an applicable advanced diagnostic imaging service is made only if the claim indicates that the ordering professional consulted with a qualified clinical decision support mechanism (CDSM) about whether the ordered service adheres to applicable AUC. Since 2020, the program has operated under an educational and operations testing period, during which ordering professionals are required to consult specified applicable AUC through qualified CDSMs and furnishing professionals must report the AUC consultation information on Medicare claims. However, CMS continues to pay claims regardless of whether AUC information is correctly indicated on the claim. In the proposed rule, CMS proposes to further delay the payment penalty of the program from January 1, 2022, to January 1, 2023, due to the ongoing COVID-19 PHE.

CHA strongly supports this proposal and appreciates that CMS recognizes the impact of the COVID-19 PHE on hospital operations and their ability to integrate the required AUC program processes into workflow and billing systems. We also appreciate that CMS clarifies that extreme and uncontrollable circumstance hardship exceptions will be available on a case-by-case basis under the process established in the CY 2019 PFS final rule. However, we remain concerned that the AUC program as required by law imposes regulatory requirements that compel action by ordering professionals — but imposes payment consequences for hospitals furnishing the service if the ordering professional fails to meet their requirements. Notably, for the educational and operations testing period, CMS has established a HCPCS modifier, "MH - Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider." In the proposed rule, CMS notes that when the payment penalty phase of the program begins, these claims will be ineligible for payment and, therefore, proposes to repurpose the modifier for additional situations.

Specifically, CMS proposes to redefine modifier MH to describe situations where the ordering professional is not required to consult AUC, and the claim is not required to report the AUC consultation, such as if the service is furnished in a critical access hospital or other circumstances that fall outside the scope of the AUC program requirements. **CHA opposes this proposal and urges CMS to maintain the MH modifier to identify the ordering professionals who fail to consistently consult AUC as required by PAMA.**

CMS says that based on its review of 2020 Medicare claims, only an estimated 9% to 10% of all claims subject to the AUC program reported sufficient information to be considered compliant with the program. An additional 6% to 7% of claims included some relevant information but lacked sufficient information required for payment if the penalties were in effect. **CHA is concerned that this indicates a low level of awareness of the requirements, and we urge CMS to conduct significant educational and technical assistance efforts prior to implementation of payment penalties. Further, CMS should continue to analyze claims to ensure a significantly higher percentage of furnishing claims report-compliant AUC information and consider additional delays in future rulemaking.**

E&M Services

Split E&M Visits

Physicians in a facility setting may bill for an E&M visit when both the billing physician and a non-physician practitioner in the same group each perform portions of the visit, but only if the physician performs a substantive portion of the visit. CMS proposes to define the “substantive portion” of the split (or shared) visit as more than half of the total time spent by the physician and non-physician practitioner performing the visit. CMS further proposes that the distinct time of service spent by each physician or NPP furnishing a split (or shared) visit would be summed to determine total time of the visit. This would establish who provided the substantive portion of the visit and, therefore, who bills for it. **CHA strongly opposes this definition of the “substantive portion” of the split visit.**

We disagree with CMS’ stated belief that time is a more precise factor than medical decision-making for deciding which practitioner performs the substantive portion of the visit. Fundamentally, E&M codes are designed to reimburse providers based on the cognitive services they provide to patients and the complexity of the medical decision-making. In many instances it is likely that the physician will provide most of the medical decision-making without having spent more than half of the total time in the room with the patient. **Similar to the recently updated E&M coding guidance, CHA encourages CMS to also allow for the determination of the “substantive portion” of a split visit based on who provided the preponderance of the medical decision-making according to the provider’s attestation. Not only will this address concerns about the administrative burden of tracking time during the split visit, but it will more appropriately reimburse the service based on the degree of cognitive services provided.**

Critical Care Services

CMS proposes several policies related to critical care services, including a proposal to bundle critical care visits with procedure codes that have a global surgical period. CHA is concerned with the impact of this proposal on critical care physicians, who often are compensated at least partly based on productivity, and provide different services than physicians who perform surgery during the global surgical period. Prohibiting the billing of critical care visits during the same time period as a procedure with a global surgical period could artificially limit these physicians’ compensation by reducing visit volume and

jeopardizing the portion of their payment tied to productivity. **CHA urges CMS to reconsider this proposal.**

Rural Health Clinic Per Visit Limit

Section 130 of the CAA restructured payment limits for RHCs beginning on April 1, 2021. The provision limits the growth rate of existing RHCs that are provider based to a hospital with fewer than 50 beds to the greater of the per visit payment amount (all-inclusive rate) — applicable to such RHC for services furnished in 2020 — increased by the percentage increase in the Medicare Economic Index (MEI) or the national statutory payment limit for RHCs per visit. Section 130 also subjects all new RHCs (including provider-based RHCs in a hospital with fewer than 50 beds and enrolled in Medicare after December 31, 2020) to the national statutory payment limit. The CY 2022 PFS includes proposals to implement the RHC per-clinic visit limit. These proposals include defining an existing provider-based RHC, methodology for counting beds, determining the 2020 base rate on which to apply the MEI, and Medicare cost report filing requirements for "new" provider-based RHCs.

In general, CHA is deeply concerned about Congress' decoupling of a RHC's all-inclusive rater (AIR) from the costs to provide services and limiting the AIR's growth to the MEI. Cost-based AIRs were intended by Congress to recognize the higher costs associated with providing services in rural areas where limited population sizes make it difficult to spread the costs of recruiting and retaining physicians and purchasing the equipment to provide specialty services closer to a patient's home across a higher volume of patients. **We ask that CMS work with Congress to address this issue, as we believe this undermines the administration's stated goal[3] of ameliorating health equity issues — particularly those faced by individuals living in rural areas.** Many of CHA's members that, prior to passage of the CAA, were planning to open new RHCs in the communities they serve are rethinking these projects. At a minimum, they are scaling back the scope of services the RHC will offer — for example, not recruiting an OB/GYN to staff a planned new clinic — or in some cases canceling the project altogether because these services, which are greatly needed by their communities, are now economically unsustainable at the national statutory payment limit or capped rate for grandfathered RHCs. Below, please find CHA's comments on CMS' specific proposals.

Definition of an Existing RHC

As defined by the CAA, "existing" provider-based RHCs in hospitals with fewer than 50 beds must have either:

1) Been enrolled in Medicare as of December 31, 2020, or
2) Submitted an application for enrollment in Medicare that was received not later than December 31, 2020.

These provisions apply to provider-based RHCs that were temporarily enrolled or applied for temporary enrollment as of December 31, 2020, to meet the needs of the PHE and that later apply for permanent enrollment. In general, CHA is supportive of this definition. **However, given the COVID-19 PHE, we ask CMS to provide additional flexibilities for provider-based RHCs that were under development prior to the passage of the CAA.**

[3] https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf

First, given the COVID-19-related challenges some RHCs have encountered in completing the certification process, we ask the agency to confirm that provider-based RHCs whose enrollment application was received by CMS as of December 31, 2020, will not be required to complete their certification process by the end of 2021. Given the limited number of certification entities, completing this process takes as much as six months under normal circumstances. COVID-19 has, unfortunately, added months to the process. Second, we ask that CMS expand the definition of “existing RHCs” to include hospital-based clinics that can provide proof of material efforts to establish a new RHC before December 31, 2020. Examples of “material efforts” include but are not limited to a signed lease for clinic space or signed contracts with an architecture, engineering, or construction firm to configure new space or reconfigure existing space. CHA does not believe it should be necessary for a provider-based RHC that was in process to provide more than one of the items described above. Given the ongoing PHE, health systems have been forced to reallocate the administrative resources necessary to bring a new RHC online to ensure there is adequate capacity to care for all of those stricken by COVID-19 in their rural communities, where access is limited to start.

CHA also asks that CMS clarify that if an existing RHC needs to change its address or otherwise alter its enrollment application, this will not negate the RHC’s existing status, subjecting it to the national statutory payment limit. We believe this clarification is necessary to assure health systems can expand existing RHCs to better meet the needs of underserved communities or rebuild an RHC if it is impacted by fire, flood, earthquakes, or other events beyond the RHC’s control.

Bed Limit
The hospital to which the RHC is provider-based must also continuously maintain fewer than 50 beds (except as provided during the COVID-19 PHE) after December 31, 2020, to qualify for the higher limit. If the hospital’s number of beds increases to 50 or above, the provider-based RHC will be subject to the same limits as freestanding RHCs and will not be able to regain the higher limit. The proposed rule appears to limit hospitals’ ability to flex bed capacity to the existing COVID-19 PHE. CHA is deeply concerned that if a rural hospital expands capacity to 50 or more beds on a temporary basis to respond to a future public health emergency (either national or localized) its provider based RHC will lose existing status and be subject to the national statutory payment limit. **We ask CMS to clarify in the final rule that a hospital with an “existing” provider-based RHC may temporarily increase capacity to 50 or more beds in response to any future localized or national public health emergency without being penalized by losing its “existing RHC” status.**

To determine if an RHC was provider-based to a hospital with fewer than 50 beds as of December 31, 2020, the Medicare audit contractor (MAC) generally conducts ongoing reviews two times per year. The rules for counting beds are described in §412.105(b). In response to the PHE for COVID-19, CMS will use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count for 2020. **CHA asks that CMS reduce the administrative burden on both MACs and hospitals by determining a hospital’s bed count once a year, based on that year’s Medicare cost report. We strongly support the continuation of CMS’ policy to use the official hospital bed count from the period prior to the start of the PHE as a hospital’s official bed count for 2020 and years included in the PHE determination.**

Determining the 2020 Existing RHC Base Rate
With regard to determining the base rate, CMS interprets "services furnished during 2020" to mean that it should instruct MACs to use the AIR based on the cost reporting period that ended in 2020. In general, CHA supports this. However, we ask CMS to provide additional details related to this process. Hospitals file an initial cost report that may be subject to audit adjustments prior to final settlement. Will CMS use only the as-filed cost report to determine a provider-based RHC's AIR, or will it subsequently adjust the AIR based on the final settled 2020 Medicare cost report? Additionally, how will CMS treat any subsequent adjustment to the AIR that is the result of a successful appeal by the hospital to the Provider Reimbursement Review Board (PRRB)? It is not uncommon for this process to take more than four years for a cost report to be final settled and appeals to the PRRB can take even longer to resolve.

If CMS opts to adjust the base rate from the as filed to the final settled 2020 Medicare cost report, CHA requests that CMS not retroactively recoup any potential overpayments that may accrue as a result of audit adjustments that ultimately reduce the AIR. We are concerned that requiring RHCs to make what could be a significant lump-sum repayment for multiple years will create a substantial financial burden for these hospitals. Instead, we ask the agency to incorporate the audit adjustments into the RHC's AIR prospectively for future years.

Medicare Cost Reports for New Provider-Based RHCs
For multi-facility RHC systems, CMS has allowed for consolidated cost reports. Beginning with RHCs enrolled in Medicare as of January 1, 2021, CMS will no longer allow new provider-based RHCs to file consolidated cost reports, as these RHCs will be subject to lower national limits while other provider-based RHCs may be subject to higher limits based on 2020 reasonable costs per visit, increased by the MEI. **CHA asks CMS to clarify that a hospital that adds a "new" RHC that is subject to the lower national statutory payment limit may still include the new RHC on a consolidated cost report as long as the new RHC is reported using a separate cost reporting line number. We believe this solution will reduce the administrative burden on both hospitals and MACs while achieving CMS' goal of segregating the cost to provide care in existing RHCs from new RHCs.**

Medicare Shared Savings Program (MSSP)

CMS proposes multiple changes related to the MSSP, including providing additional time for certain quality reporting and measurement requirements, beneficiary attribution, reducing the administrative burden, and decreasing the financial cost of participating in the program. CMS also requests feedback related to opportunities to improve the MSSP benchmarking and risk adjustment process. CHA is generally supportive of the proposed changes and appreciates CMS' efforts to improve the MSSP for both beneficiaries and participants.

Quality Reporting
In the CY 2021 PFS rule, CMS finalized that the web Interface would no longer be available, and Shared Savings Program accountable care organizations (ACOs) would be required to report under the APM Performance Pathway (APP) using their choice of other data submission types (e.g., eCQM) starting in CY 2022.

However, in the current proposed rule, CMS proposes that for the CY 2022 MSSP performance year, MSSP ACOs would be permitted to report either the current MSSP measure set via the CMS web

interface or the MIPS APP measure set. In CY 2023, the agency proposes that ACOs that choose to report the web interface measure set also would be required to report at least one measure from the APP measure set. Starting in performance year 2024 and thereafter, MSSP ACOs would be required to use the APP to report quality data.

CHA strongly supports CMS' proposal to allow MSSP ACOs the option of continuing to report quality measures using the CMS web interface for 2022 and 2023. Even with this extended transition period, CHA has significant concerns with CMS' proposal to eliminate the web interface as a reporting option for CY 2024. First, as a practical matter, submitting quality data using electronic health records (EHRs) or one of the other mechanisms requires creating a Quality Reporting Document Architecture (QRDA) file. This significantly increases the administrative burden for ACOs that are comprised of multiple physician practices.

As an example, one of CHA's members anchors an MSSP ACO that includes over 100 tax identification numbers. The various practices that participate in the ACO use over 30 different EHR systems. This organization estimates that ingesting and cleaning the necessary quality data from its MSSP participant practices to create a QRDA file to submit eCQMs will add $1 million per year to the overhead cost of running the ACO. Beyond the increased cost of submitting data, CHA notes there are still some community physician practices that participate in MSSP ACOs and lack an EHR. CHA's members are concerned that if the web-interface reporting option is eliminated, it will not be practical for these practices to continue to participate in the MSSP. Any reduction in the number of physicians who participate in programs like the MSSP is contrary to CMS' stated goal of expanding the number of Medicare beneficiaries who receive their care from providers actively involved in value-based payment models.

Second, CHA's members are concerned that the data collection types that will be available to ACOs in CY 2024 and thereafter — EHRs, qualified registries, and qualified clinical data registries — all require data to be collected on an all-payer basis, and not simply on Medicare beneficiaries. The financial performance for MSSP participants, who have agreed to assume risk only for outcomes related to their Medicare patient population, will be in part determined on an all-payer basis. This is particularly concerning for MSSP participating physicians whose panels have significant numbers of patients with unmet social needs. If these practices don't have a corresponding risk-sharing payment model offered by the payer that is responsible for patients with unmet social needs, the practice may not have the resources necessary to address issues that negatively impact measures like hemoglobin A1c and high blood pressure control. Also, moving to an all-payer measurement base disadvantages MSSP ACOs that have chosen to include specialists in the participating physician list. In many instances — for patients who are not attributed to them directly — the patient will be using the specialist for a specific clinical issue and not for primary care. Therefore, the specialist will likely not provide most of the primary care screenings, which will give the ACO the appearance of lower performance on the APP measure set.

CHA is concerned that expanding the denominator of measures used to determine MSSP quality scores to include non-Medicare patients will likely cause some MSSP participants to drop out of the program given it will, when coupled with the proposed increased quality standard beginning in CY 2024, disadvantage certain types of providers. **Based on both the increased administrative cost and the likelihood that some MSSP participants will leave the program, CHA respectfully asks CMS to delay**

eliminating the web reporting interface indefinitely until it can develop alterative reporting options that do not carry the same unintended consequences for both MSSP participants and their patients.

Quality Standard
The quality standard was revised for PY 2021 to align with the transition of MSSP ACOs from web Interface reporting to reporting via the APP. In this rule, CMS proposes further revisions to reflect the proposed quality reporting described above, including delaying adoption of a higher standard (40th percentile) until PY 2024, allowing ACOs additional time to prepare for the transition to APP reporting. **CHA appreciates CMS delaying increasing the performance standard from the 30th to 40th percentiles.** As discussed above, there are significant issues related to including non-Medicare patients in ACO quality performance assessment. If these issues are not resolved, we are concerned that MSSP participants will exit the program. **Therefore, CHA respectfully asks CMS to further delay increasing the quality standard until the issues discussed above have been adequately addressed.**

Primary Care Codes for Beneficiary Attribution
CMS proposes updates to the list of primary service codes to be used beginning with PY 2022 for beneficiary assignment to Shared Savings Program ACOs. The agency also proposes to extend the duration of use of telephone E&M codes 99441 through 99443 for beneficiary assignment until utilization analyses can be conducted and a decision reached about permanently adding these formerly non-covered services as covered services to the Medicare telehealth list. **CHA supports the additional codes added by the proposed rule to assign beneficiaries to an ACO. We also appreciate CMS extending the use of telephone E&M codes 99441 through 99443 to conduct further analysis to determine if they should be permanently added to the covered service list.**

Repayment Mechanism
Based on analysis of prior data, CMS has determined that the repayment mechanism amounts for most ACOs are larger than needed to cover actual losses. To reduce the repayment mechanism amounts MSSPs are required to maintain to better reflect the amounts needed to cover potential program losses, CMS proposes four changes to the repayment mechanism calculation. These changes include:

- Modifying the methodology for calculating repayment mechanism amounts to reduce the required amounts
- Specifying how CMS identifies the number of assigned beneficiaries used in the repayment mechanism amount calculation and the annual repayment mechanism amount recalculation
- Permitting eligible ACOs in two-sided risk models a one-time opportunity to reduce their repayment mechanism amount
- Modifying the threshold for increasing an ACO's repayment mechanism amount during its agreement period

CHA supports these proposals, as we believe reducing the required repayment amount will decrease providers' cost of participating in the MSSP.

Application Requirements
CMS has found that the document submission requirements substantially increase applicant burden without lending significant value to the review of an organization's application to confirm that the ACO

meets the eligibility requirements for participation. The CY 2022 PFS includes three proposals intended to reduce the burden of applying to participate in the MSSP. These changes include:

- Prior participation disclosure is required only when requested by CMS during the application process.
- Sample ACO participant agreements only need to be submitted during the application process if requested by CMS.
- ACOs are no longer required to submit an executed ACO participant agreement for each ACO participant at the time of its initial application or participation agreement renewal process.

CHA supports these proposals, as we believe they will decrease the administrative burden associated with applying to participate in the MSSP.

Request for Information – Benchmarking
While CMS does not propose any changes to the MSSP benchmarking methodology, it discusses well-documented concerns that the current methodology penalizes efficient ACOs, particularly those with high-market shares like many rural MSSP participants. In response to these concerns, CMS advances a possible approach to adjust its benchmarking methodology to address these concerns. This approach uses the ACO's average per capita risk-adjusted fee-for-service (FFS) expenditures for its assigned beneficiaries and the per capita risk-adjusted FFS expenditures for all assignable beneficiaries to derive the risk adjusted per capita FFS benchmark for all assignable beneficiaries who are not attributed to the ACO. **CHA greatly appreciates CMS' interest in adjusting its benchmarking methodology so as not to penalize more efficient ACOs.**

We believe the approach described in the proposed rule is directionally correct. It removes the ACO's assigned beneficiaries from the benchmark using a relatively simple methodology. However, it does not appear to remove beneficiaries that are attributed to other CMS shared risk models (e.g., other MSSPs, ACOs, or Direct Contracting Model participants) from an ACO's benchmark. **Therefore, in addition to removing beneficiaries who are attributed to an ACO from that ACO's benchmark, we strongly recommend that CMS refine its proposed methodology to remove beneficiaries attributed to all CMS shared risk models from the benchmark, so that an ACO's cost-efficiency is compared to the FFS population.** This approach will encourage providers to continue participating in the MSSP because it will be possible for them to continue generating savings for the Medicare program and receiving shared savings to offset the considerable infrastructure costs associated with maintaining an integrated delivery system.

Request for Information – Risk Adjustment
CMS uses CMS-Hierarchical Condition Categories (HCC) prospective risk scores to adjust the historical benchmark for changes in severity and case mix for all assigned beneficiaries. The adjustment is subject to a cap of 3% for the agreement period. ACOs and other stakeholders have expressed concerns that the program's methodology for capping any increase in the risk adjustment to the historical benchmark does not account for risk score growth in the ACO's regional service area, and thereby penalizes ACOs. In the proposed rule, CMS seeks comment on approaches to improving the risk adjustment methodology — specifically for ACOs with medically-complex, high-cost beneficiaries. CHA greatly appreciates CMS'

interest in improving its risk adjustment methodology to account for ACOs that manage medically complex patients.

CHA urges CMS to amend its current risk adjustment policy to use a more appropriate risk adjustment cap of 5%. We also believe the methodology could be improved by adding a symmetrical floor that limits reductions to negative 5%. CHA strongly believes that the benchmark for a given performance year needs to be fully adjusted for changes in beneficiary health status. Failing to do so ignores the fact that even when care is optimally managed, individuals become sicker and, therefore, more expensive to care for as disease processes progress (or initially present). For example, when a beneficiary who has been continuously attributed to an ACO is diagnosed with cancer, it is inappropriate for the ACO to be responsible for that cost with no expectation from Medicare for higher spending related to that member. Without an appropriate adjustment to the risk score to reflect the onset of an acute condition, the MSSP has assumed insurance risk, not simply care management risk. **Therefore, we encourage CMS to explore ways to implement the Center for Medicare & Medicaid Innovation-HCC concurrent risk adjustment model[4] in the MSSP.** Concurrent risk models are better able to predict costs for populations with high disease burden or who are otherwise seriously ill, because the approach can better capture a rapid deterioration in health in the current year, such as through the occurrence of acute episodes that are difficult to predict or prevent (e.g., heart attack). This is a departure from the existing CMS-HCC prospective risk adjustment model, which predicts current-year costs using health status indicators (diagnoses) from the prior year.

Expansion of Coverage for Pulmonary Rehabilitation

CHA strongly supports CMS' proposal to expand coverage of outpatient pulmonary rehabilitation services to beneficiaries diagnosed with "severe manifestations" of COVID-19. "Severe manifestations" would be defined as patients requiring hospitalization in the ICU or who otherwise experience continuing symptomatology, including respiratory dysfunction, for at least four weeks post-discharge. As hospitals and post-acute care providers learn more about treating severe and long-term manifestations of COVID-19, it is important to ensure Medicare beneficiaries have access to outpatient pulmonary rehabilitation services.

CHA appreciates the opportunity to comment on the PFS proposed rule for CY 2022. If you have any questions, please do not hesitate to contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Chad Mulvany at cmulvany@calhospital.org or (202) 488-4688.

Sincerely,
/s/
Megan Howard
Vice President, Federal Policy

[4] Direct Contracting Model: Professional and Global Options and Kidney Care Choices Model - Risk Adjustment, RTI International, pg. 17