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Administrator Seema Verma
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Room 445-G
Washington, D.C. 20201

Re: Medicare Program; Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021 (CMS-1734-P)

Dear Administrator Verma:

The University of California Health system welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) CY 2021 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule (85 Fed. Reg. 50074). The University of California's health system is comprised of six academic health centers located at Davis, Irvine, Los Angeles, Riverside, San Diego, and San Francisco, which are collectively known as UC Health.

Together, UC Health's academic health centers assume responsibility for training half of California's 11,000 medical residents and offer some of the highest quality, most complex and innovative medical services in the nation, while simultaneously serving as one of California's highest volume safety net providers.

Teaching physicians who work at academic health centers, including UC Health, deliver medical care in some of the country's largest physician group practices. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of which require highly specialized care. Often, care provided through these large physician groups is multidisciplinary and team-based. Frequently, our large physician groups comprising our academic health centers' faculty practice plans include many specialties and subspecialties, such as burn care, cardiac surgery, and pediatric oncology. A significant percentage of the services UC Health provides are tertiary, quaternary, or specialty referral care. A patient may be transferred to, or seek care at, a UC Health academic health center, because the care needed is not available in the patient's community or region.

UC Health lauds CMS for efforts it has undertaken during this Public Health Emergency (PHE), to relax Medicare rules around delivery of medical services via telehealth, to recognize clinicians, including medical residents, for the time they spend with patients and the sophistication of services they deliver, and to ease physicians' path towards achieving greater volume of value-based care.

We want to partner with CMS to ensure that Medicare payment policies promote access to high quality care for patients, accurately reflect the resources involved in teaching physicians treating patients, and are not overly burdensome to clinicians.

While we are pleased to support many of CMS's proposals, detailed below, we continue to urge the agency to work with Congress to remove statutory barriers to the greater adoption of telehealth.

I. Facilitating Greater Use of Telehealth to Deliver Medical Care

Several UC Health academic health centers are separated geographically from each other by several hundred miles. However, the system's enhanced use of, and dependence on, telehealth as a modality for delivering care has in part eroded the effect of geographic distances among some UC health centers, allowing patients to benefit from receiving treatment from highly skilled specialist and sub-specialist physicians working throughout the UC Health system. Flexibilities the Administration has granted to providers around their use of telehealth during this PHE have allowed UC Health to demonstrate to patients via telehealth services that the sum of physician capabilities throughout our system exceeds what any individual UC Health academic health center can provide.

We offer the following feedback on telehealth policy proposals set forth in the CY 2021 Medicare Physician Fee Schedule:

- Endorse CMS's proposal to support for live voice/video telehealth services for the duration of the COVID-19 PHE.
- Encourage CMS to expand the list of Medicare telehealth services to permanently include services that were added during the PHE, including services that can be provided audio only.
- Maintain the sub-regulatory process for adding additional services to the telehealth coverage list put in place during the PHE.
- Recognize the statutory restrictions CMS faces in extending some of the telehealth flexibilities tied to delivery of Medicare services past the expiration of the PHE.
- Support CMS's proposed policy changes to expand Part B support for Medicare telehealth services, including the creation of a new Category 3 for services enabled during the PHE period.
- Urge CMS to permanently allow use of virtual check-ins and e-visits for new and established patients.
- Commend CMS's efforts to minimize burdens on caregivers, and agree that patient consent for CBTS may be documented by auxiliary staff under general supervision.
- Allow ICD-10 diagnosis from telemedicine services to be used in CMS risk adjustment methodologies for Medicare Advantage and other programs.

We offer the following recommendations in response to specific payment code proposals set forth in the CY 2021 Medicare Physician Fee Schedule.

1) **Based on CMS's proposed clarifications on remote physiologic monitoring (RPM) CPT Codes 99453, 99454, 99457, and 99458, we offer the following:**

    a. CMS is stating in this rule 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. The agency has converted RPM into an evaluation and management service instead of a chronic care management service. By stating that the 20 minutes of RPM must be patient-provider interactive, the purpose for reclassifying it is defeated. CMS's proposed interpretation of "interactive communication" runs counter to stakeholders' experiences and expectations, as well as the nature of RPM technology, and is inconsistent with CMS's approach to chronic care management services as well as widespread practices and experiences in the field. Unless corrected, CMS's proposed approach would significantly undercut the ability to furnish RPM.

    b. CMS should correct its proposed approach to CPT Codes **99091** and **99457** being billed in the same month or being billed in conjunction, which is inconsistent with the CPT Codebook that clearly states that **99091** should not be billed in the same calendar month as the **99453, 99454, 99457, and 99458 codes.**

    c. CMS should clarify that **99453** and **99454** may be billed by a provider once per month per patient with no limitation on the number of providers. Patients suffering from multiple illnesses that require monitoring under different care plans should benefit from RPM services for each of those illnesses as medically appropriate.

    d. The Physician Fee Schedule includes practice expense as a payment. This leaks into durable medical equipment (DME) and other equipment. It is not a physician expense. It appears there should be a HCPCS code for the equipment. Formerly, there was an option that the patient could provide the equipment, so long as the calibration was acceptable. Now, it is incumbent on the provider to supply the device. The Physician Fee Schedule considers the device to be "equipment" under its pricing methodology and not a supply. Supplies for Physician Fee Schedule purposes are only for things that are used up like the diabetic test strips. The term "device supply" in the CPT Code descriptor means that whoever is billing the code supplies the device to the patient. We find this wording to be awkward.

2) **We ask CMS to understand our RPM considerations under codes 99457 and 99458.**

    a. We encourage CMS to extend its PHE policy enabling RPM services to be reported to Medicare for periods of time that are fewer than 16 days, but no less than two days, if other requirements for billing are met. Numerous use cases across chronic and acute conditions illustrate that a requirement of 16 days is not always appropriate.

    b. **99457-** If the requirement for real time communication persists, then the full 20 minutes of the code should include the time spent for review, analysis, and documentation to the patient chart. CMS is proposing a very restrictive definition; which also requires patient interaction. It is doubtful that CMS can change the definition unless it creates a separate G code.

    c. **99458-** CMS defining if the entire 20 minutes must be used to bill **99458,** or just over half of the time, would be useful.

II. MIPS Proposals

As California's leading safety net providers, UC Health's academic health centers provide primary and secondary care to patients of all economic means. Each of UC Health's academic health centers have taken a proactive approach to managing patient populations, and they voluntarily began utilizing value-based care models to deliver care to a broad array of patient populations. We believe that through these Alternative Payment Models (APMs), we will provide more efficient, higher quality and innovative medical care to Medicare beneficiaries who will have a better health care experience. Currently, all UC Health academic health centers participate in some type of APM. We ask for CMS's help facilitating greater provider participation in APMs.

The following are a few updates proposed in the CY 2021 Physician Fee Schedule proposed rule that impact MIPS and consequently, the incentives for, and capacity of, our physicians to participate in APMs that promote high quality and efficiently delivered patient care for Medicare beneficiaries.

- **CMS is proposing to use the 2021 performance year to establish quality measure benchmarks due to many organizations not having submitted data for 2019. CMS is soliciting input on whether to calculate the 2021 benchmarks using 2021 (current year), 2020 (previous year), or historic 2018 data for its benchmarks.**

UC Health would support use of 2018 benchmarks for 2021 quality measures. This will allow for continued evaluation of measure performance and compliance throughout the measurement year, while the other two options will not give us the same opportunity to know what we are being benchmarked against.

CMS has performance year 2018 data. The performance year 2019 data was not fully collected due to the COVID-19 crisis. We agree, performance year 2020 data should not be used at all because it will be distorted in unknown ways due to the COVID-19 crisis. We suggest either use performance year 2018, or allow catch-up continued submission of performance year 2019 data, and adjust the benchmark percentiles so that providers are not disadvantaged.

- **CMS is proposing to expand the list of telehealth visits that include quality and cost measures in 2021.**

UC Health supports having expanded telehealth services. However, inclusion in the denominator across our measures does not translate to numerator compliance. There is certainly impact to administrative burden, and we want to ensure data is captured and mapped appropriately for reporting. Use of telemedicine services for important clinical conditions is not yet fully understood. Some types of quality measurements (numerator compliance) may not be easily obtained via telemedicine or require additional infrastructure development such as remote monitoring. There should be additional time for adaptation.

- **CMS calls for altering the start date of the Section 203 SUPPORT Act requirement, which generally requires that the prescribing of a Schedule II, III, IV, or V controlled substance covered under a Medicare Part D prescription drug plan or Medicare Advantage Prescription Drug Plan be done electronically in accordance with an electronic prescription drug program, with prescribers using the National Council for Prescription Drug Programs (NCPDP) Script 2017071 standard for EPCS prescription transactions by January 1, 2021 and requiring EPCS by January 1, 2022. CMS has issued a Request for Information in which it seeks feedback on how to implement requirements in the future.**

UC Health suggests that CMS not impose penalties for failing to adopt the requirements and instead, incentivize provider organizations' adoption of the requirements, particularly for those organizations prepared to meet the January 1, 2021 deadline. We would like to suggest as an incentive extra points in the Promoting Interoperability Program category for 2021 adopters.

- **CMS proposed that by August 2, 2022 organizations need to use software certified by the Office of the National Coordinator's (ONC) 2015 Cures Edition Criteria to participate in MIPS. This certification edition was created as part of the 21st Century Cures Act statute's rules.**

The Office of the National Coordinator for Health Information Technology (ONC) communicated in the CURES Act final rule that the deadline for Health IT developers, like EPIC, to make this technology available to health care organizations is also August 2, 2022. There are at least two points to consider: the conflict between when the technology should be made available and provider adoption of the new technology, along with a request for CMS to review historical issues and allow for flexibility for adoption. Since developers have until August 2, 2022, to make the technology available, that date shouldn't be the same date upon which providers must show use. We suggest 3-6 months after August 2, 2022, as a reasonable time frame upon which providers must show use.

- **CMS has proposed a new optional objective measure for MIPS Promoting Interoperability Health Information Exchange (HIE) Bi-Directional Exchange for 2021. The new measure is offered as an alternative to our current two challenging HIE measures and is worth 40 points. Unlike our current HIE measures, the new measure is being introduced as a yes or no attestation.**

This new, optional measure appears to be a strong solution for UC Health providers. We would like for CMS to allow for exclusions based on an individual patient's privacy request and potential state laws that would restrict information from being sent through an HIE. We assume there will be a provision for exclusion from the denominator and numerator for patients who request it, or due to other regulations. We would also be in support of proposing the same alternative measure to both the hospital and Medicaid Promoting Interoperability Programs.

III. Virtual Supervision by Teaching Physicians

UC Health appreciates CMS's efforts during the PHE and proposals included that aim to make permanent some of the regulatory flexibilities offered during the PHE. These flexibilities have allowed teaching hospitals to meet the needs of their communities during the PHE.

UC Health supports extending flexibility related to virtual supervision of a medical resident on a permanent basis. As the resident or fellow advances through his/her graduate medical education training and demonstrates increased competency, there is a graduated level of responsibility and decreasing level of supervision allowing more autonomy and readiness for independent practice. With virtual supervision, senior residents or clinical fellows are first to see the patients via telemedicine. After discussing a patient's case with the attending physician, the resident or fellow joins the patient visit to confirm key elements of medical services. For interns or more junior residents, the attending physician is with the resident "in the room," whether conducted in-person or virtually, throughout the visit. The more junior the resident, the more involved the teaching physician needs to be in supervising the resident.

Teaching physicians can effectively supervise residents at all levels via use of telecommunications technology. The use of telecommunications technology presents no new risks to supervising a resident versus supervision of in-person patient visits, other than making sure telecommunications technology works. Our physicians speak to there being more applications and medical devices available that facilitate making it easier and safer to see patients virtually. Our physicians also find that telecommunications technology furthers patient care by allowing for faster access and potentially better healthcare outcomes. For example, a UC stroke team working with an Emergency Department faculty member can provide information to a medical resident via telecommunications; this allows stroke patients to receive care more quickly. We see telemedicine as being here to stay, as physicians and patients both really like it.

While we have seen tremendous value in healthcare delivered via telecommunications, there are still gaps in outpatient care visits that cannot be filled by telehealth and that may exacerbate longstanding health disparities. In-person care is still needed.

IV. Moonlighting Residents' Professional Billing

UC Health is generally supportive of allowing residents to bill separately for professional services that are unrelated to their approved Graduate Medical Education (GME) training program and furnished to hospital inpatients if those services are: (1) identifiable physicians' services; (2) can be separately identified from services that are required as part of the resident's approved GME training program; and (2) the services meet the requirements for state licensure. This billing option is well-suited to fellows who are already Board- certified or Board-eligible in their first specialty and are competent to provide services independently in that first specialty while pursuing a fellowship that can be clearly distinguished from the services that are part of the resident's approved GME training program (*e.g.*, clinical informatics fellows, who typically have completed their first Board in any number of specialties or OB/GYN subspecialty fellows providing routine labor and delivery services).

UC Health recommends that CMS extend this billing separately flexibility on a temporary basis through at least the end of the calendar year 2021, because this flexibility has been critical to support staffing relief for overtaxed hospitalists responding to COVID-19 pandemic. We ask that CMS revisit this policy next year to consider whether to make a permanent change, thereby allowing more time for stakeholders' input. We believe that it is important from an education and patient safety perspective that the flexibility supports moonlighting activities by residents who are competent to provide services independently but does not create a slippery slope for residents to be performing independently services for which they are still in training.

V. "Incident to" Physician Services and Physician Supervision Requirements during the Public Health Emergency

UC Health supports CMS's clarification that Medicare Part B payment may be made for pharmacist services (*e.g.*, medication management services) delivered "incident to" physician services furnished in an office setting and under the "direct supervision" of the physician.

VI. Teaching Physician/Resident "Primary Care Exception"

UC Health supports CMS's proposals to expand the "primary care exception" that allows payment for professional services to teaching physicians for services furnished by a medical resident in a teaching hospital primary care center without the physical presence of a teaching physician. We additionally support the parallel policy change of allowing a teaching physician to establish his/her presence virtually.

Conclusion

UC Health is committed to ensuring that our patients receive affordable, high quality, patient- centered care. We appreciate for your consideration of our recommendations concerning the polices proposed in the CY 2021 proposed rule for the Medicare Physician Fee Schedule. If you have any questions about our comment letter, please contact Julie A. Clements, JD, MPP, Director of Health and Clinical Affairs (Julie.Clements@ucdc.edu/(202)-974-6309), Office of Federal Governmental Relations for the University of California system.

Sincerely,

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