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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
ATTN: CMS-1734-P
Mail Stop C4-26-05
7500 Security Blvd.
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; et al.**

Dear Administrator Verma:

The undersigned are pleased to submit comments in response to proposed revisions to the Medicare Physician Fee Schedule (MPFS) for CY 2021. We are a group of specialty societies whose members care for patients in residential settings, including patient's homes, domiciliary facilities, and nursing facilities. Our comments are limited to Section II. F, the solicitation for comments and input on ways to reform the documentation guidelines for Evaluation & Management (E/M) services.

We appreciate the continued engagement by the Centers for Medicare & Medicaid Services ("CMS") with stakeholders on appropriate payment for evaluation and management ("E/M") services. We strongly believe that Medicare must appropriately value these services which are at the core of high quality, person-centered care. However, we are concerned about the negative impact that changes to the office/outpatient E/M codes payment will have on payment for all services paid under the PFS. CMS proposes a reduction of 10.61 percent in the PFS conversion factor which will result in significantly lower payments to those physicians who primarily provide care to patients' in their residence and therefore do not report E/M services using the office/outpatient codes. We urge CMS to take all possible steps to minimize this impact and to continue to work with specialty societies to ensure appropriate valuation of E/M services in all settings.

Specifically, we recommend that CMS:

- Adjust the work RVUs for the nursing facility, domiciliary, and home visit codes (99304 - 99318, 99324 - 99337, and 99341 - 99350) to maintain 2020 payment rates until those services can be revalued by the RUC;
- Allow the complexity add-on code (GPC1X) to be reported with E/M services furnished in the home and domiciliary care settings and further refine which practitioners can report GPC1X by use of the patient relationship codes; and

- Assume utilization of GPC1X in 2021 of 23 percent of total expected utilization, consistent with experience with other new E/M codes.

A. CMS Should Consider the Nursing Facility, Domiciliary, and Home Visit Codes to Be Analogous to the Office/Outpatient Codes and Adjust the Work RVUs to Avoid Reducing Payments for those Services.

CMS states in the rule "we believe that the magnitude of the changes to the values of the office/outpatient E/M visit codes and the associated redefinitions of the codes themselves are significant enough to warrant an assessment of the accuracy of the values of services containing, or closely analogous to, office/outpatient E/M visits."[1] We are particularly concerned about the magnitude of the impact the proposed changes will have on E/M services furnished to patients in their residences which are reported under the nursing facility, domiciliary, and home visit codes which have not been revalued for many years. We are very concerned that these settings of care are already underserved and have become even more disadvantaged and these services are even more critically needed due to the PHE. Physicians are seeking to minimize patient exposures and thus may more frequently need to make home or assisted living facility visits, particularly to avoid emergency room services whenever possible. The pandemic has created disproportionate mortality for those in nursing facilities and greater complexity for all who work there. Services at home, the assisted living facility and nursing home reduce the burden on other care settings and are best for the vulnerable beneficiary. The proposed reduction in the conversion factor will reduce the Medicare payment for those services by 8 to 10 percent. CMS should evaluate its authority to take steps to maintain payment levels for these services in order to maintain access for care.

Nursing home, domiciliary, and home visits have the same components as office visits and require similar levels of medical decision-making and therefore are closely analogous to the revalued codes. In particular, home and domiciliary services are the same as office/outpatient services in every way, except for the service location. They are relatively low volume services provided to a highly vulnerable population by professionals who are disproportionately affected by Medicare policy.

Appropriately valuing and paying for E/M services provided in those settings is especially important as the country continues to respond to the risks and challenges of COVID-19. The risk of infection may lead many patients, particularly elderly and chronically ill patients who are at elevated risk from COVID-19, not to seek care in the office setting. Services furnished in the nursing facility, home and domiciliary settings will be critical to providing access to needed care and to maintaining care relationships.

CMS could determine that the nursing facility, domiciliary, and home visit CPT codes are analogous to office/outpatient codes and adjust the work RVUs for those codes to take into consideration the changes in the values for the office/outpatient codes. We understand that the RUC will be reviewing these codes in the near future so any increase in valuation by CMS would be temporary - likely for one or two years. Our primary concern is that beneficiaries continue to have access to these services in the near term and therefore we ask that CMS revise the work RVUs for 99304 - 99318, 99324 - 99337, and 99341-99350 to the extent necessary to maintain the payment rate for these codes at 2020 levels. Additional changes in value can wait until the RUC reviews these codes and sends its recommendations to CMS. Given the relatively small volume of services reported under these codes, we do not expect that this

[1] 85 Fed. Reg. 50124.e

change would negatively impact the conversion factor. Our estimate of the RVUs required to achieve this outcome are shown below.

Table 1
Recommended Work RVUs to Maintain 2020 Payment Rates

Setting	Patient	HCPCS	Recommend Work RVU
Nursing Facility	Initial	99304	1.90
		99305	2.70
		99306	3.52
	Subsequent	99307	0.88
		99308	1.33
		99309	1.79
		99310	2.69
	Discharge Service	99315	1.48
		99316	2.19
	Annual nursing facility assessment	99318	1.96
Domiciliary	New	99324	1.18
		99325	1.75
		99326	2.99
		99327	3.95
		99328	4.70
	Established	99334	1.21
		99335	1.96
		99336	2.78
		99337	4.07
Home	New	99341	1.17
		99342	1.77
		99343	2.93
		99344	3.85
		99345	4.66
	Established	99347	1.14
		99348	1.79
		99349	2.64
		99350	3.74

B. CMS Should Allow Use of the Complexity Add-on Code with Nursing Facility, Home, and Domiciliary Visit Codes

In the proposed rule, CMS states that the new complexity add-on code GPC1X is distinct from other preventive or care management codes because "GPC1X reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time."[2] We agree that such longitudinal relationships are critical elements of high quality care and urges CMS to clarify that the add-on code can be billed in all instances where this type of intense E/M service is furnished. In particular, CMS should clarify that the add-on code can be reported with outpatient visits furnished in settings other than the office, specifically nursing facility, home and domiciliary visits (99304 - 99318, 99324 - 99337, 99341 - 99345). Domiciliary, home and nursing home visits are as complex as office visits and may be more complex because the physician is often acting as both a primary care physician and a specialist taking care of patients with acute illnesses superimposed on multiple chronic illnesses. Many members of our societies perform office visits and home visits and believe they are identical with respect to building longitudinal relationships with patients and families. In many cases patients are seen at home on a regular basis because they are homebound and unable to go to a physician office. Recognizing the visit complexity inherent to those services and allowing for reporting of GPC1X with home and domiciliary visit codes will help pay more appropriately for the care provided.

C. CMS Should Assume Utilization of Complexity Add-on Code Will Be No Greater Than 23 Percent in the First Year the Code is Available.

It is not clear from the proposed rule discussion how frequently CMS assumes GPC1X will be reported in 2021. We urge CMS to ensure that the assumption is consistent with experience of other codes in the first year of availability and does not overstate expected utilization. We note that, for most practices, the new code will not be included in billing software on January 1, 2021; it will be several months before the code can be easily included on electronic claims. This delay and the need to educate physicians about proper use of the code mean that the utilization next year will likely be well below the use that could be anticipated three to four years after implementation. For example, utilization of transitional care management services (99495 and 99496) when first effective in 2013 was 24 percent and 22 percent respectively of the 2018 volume. Utilization of the chronic care management code (99490) in its first year (2015) was 23 percent of the 2018 volume.

Based on this experience, the appropriate utilization assumption for 2021 is at most 23 percent of the anticipated full utilization for all specialties. We urge CMS to refine its methodology to include this utilization assumption.

* * *

Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Paul Rudolf at paul.rudolf@arnoldporter.com.

[2] 85 Fed. Reg. at 50,138.

Sincerely,

- American Geriatrics Society
- AMDA – Society for Post-Acute and Long-Term Care Medicine
- American Academy of Home Care Medicine
- American Psychiatric Association