

## AMGA Response to CMS RFI for Comment on Provider Experience

In response to a Centers for Medicare & Medicaid Services (CMS) Request for Information on provider experience, AMGA offered insight on how the Medicare physician payment system contributes to administrative burden and does not fully support providers' ability to care for their patients. Based on their members' extensive involvement with the Medicare program, AMGA offered a number of recommendations on the Quality Payment Program, quality measure reporting, and telehealth benefits.

### Topic 2A: Understanding Provider Experiences

*CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.*

#### **PHYSICIAN FEE SCHEDULE AND REGULATORY BURDEN CONSIDERATIONS**

Founded in 1950, AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality and high value care. Over 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

The current Medicare physician payment system presents challenges for AMGA members in meeting the needs of their patients. This is especially true during an unprecedented time of inflation, rising supply costs, and workforce shortages. The Physician Fee Schedule (PFS), which has been the target of substantial payment cuts in the 2023 final rule, does not reflect the true cost of providing quality care to Medicare beneficiaries, and imparts significant regulatory and administrative burden on healthcare providers. Loss of revenue for providers inevitably reduces patient access to services as it forces operational changes including, but not limited to the elimination of certain services, delayed investments in technology, and slowed efforts to address various social determinants of health for at risk Medicare beneficiary populations. The situation is further exacerbated by additional expenses clinicians incur through hiring consultants and allocating staff to understand and ensure compliance with regulatory requirements, particularly for Electronic Health Records (EHRs) and documentation considerations.

The Medicare physician payment system forces providers to focus on "checking boxes" rather than spending quality time with patients, listening to patient concerns, and developing comprehensive care plans. As a result, patient dissatisfaction increases as providers scramble to comply with regulatory requirements and provide quality care amidst significant financial strain and workforce shortages.

## Topic 2B: Understanding Provider Experiences – Recommendations

*Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.*

### **MACRA AND MIPS CONSIDERATIONS**

AMGA recommends the discontinuation of the low-volume threshold policy under the Merit-based Incentive Payment System (MIPS). Each year, the Centers for Medicare & Medicaid Services (CMS) updates the PFS conversion factor according to a schedule specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The MACRA budget neutrality requirements and the low-volume threshold criteria of MIPS will continue failing to carry out MACRA's original intent to reward providers for their investments in health information technology (IT), enhance care management processes, and improvements in patient care. Both those who participate in the program and those who do not will experience the consequences of the arbitrary low-volume threshold criteria. CMS estimated that two-thirds of MIPS-eligible clinicians will receive a neutral or positive payment adjustment, while approximately 10% will receive a negative one. Such an uneven distribution of scores creates a reimbursement system that is not commensurate with the investments made to transition to value-based care. AMGA does not believe this policy is consistent with congressional intent for the program and hinders the ability of providers to meet patient needs.

In addition to the lack of meaningful payment adjustments, a general lack of guidance instills the fear of failing an audit in participants during the MIPS submission process. There is no clear audit process to determine whether clinicians are meeting requirements such as data completeness and data aggregation for Electronic clinical quality measures (eCQMs). This trepidation of providers attempting to adhere to unclear audit guidance negatively influences providers' experience with MACRA. These barriers further hinder the goal of transitioning providers to value-based care delivery.

### **QUALITY MEASURES REPORTING CONSIDERATIONS**

Rather than offering menu options for selecting reporting pathways, quality measure reporting should be focused on real-time submission, real-time feedback on performance, and timely payment incentives. AMGA members have found it challenging to successfully report quality measures, making the incentive insufficient for the level of effort that this initiative requires. For example, PI\_HIE\_4 Support Electronic Referral Loops by Receiving and Reconciling Health Information is a time-consuming process that requires providers to match external descriptions to internal data. In addition, specialists are not comfortable reconciling problems outside of their specialty area. These challenges fail to effectively add value yet impose significant barriers that ultimately result in less time for care delivery. To resolve this issue, specialists should be allowed to simply indicate that they have reviewed the data to meet quality measure reporting requirements.

#### **Topic 4A: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities**

*CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.*

The impact of the COVID-19 pandemic on physicians and provider organizations are significant and ongoing. Further compounding continuing public health challenges are the economic headwinds such as inflation, supply chain and labor shortage pressures, which are significantly affecting healthcare delivery nationwide. Consequently, operational costs have increased dramatically for providers and health systems while shortages of nurses and other essential clinical staff have reached critical levels, a trend only exacerbated by unsustainable levels of staff and provider burnout.

#### **TELEHEALTH CONSIDERATIONS**

Throughout the COVID-19 Public Health Emergency (PHE), AMGA members have made difficult decisions, and altered how they delivered care by eliminating elective surgeries and procedures to limit in person visits and thereby safeguard patients and healthcare workers during the global health crisis. As a result, a significant expansion of telehealth services occurred, allowing clinicians to provide ongoing care, interactions, and treatment on new, innovative video and audio technology platforms. AMGA members reported an increase from 10 telehealth visits per month to an average of 2,000 telehealth visits per week from March 2020 to March 2021.

Prior to the pandemic, all telehealth services were required to be billed using the telehealth place of service (POS) code "02" (to identify the service as being provided via telehealth) and clinicians were paid at the facility-based payment rate. However, this CMS requirement assumed that it is less costly to provide services via telehealth than in a clinician's office, as the facility-based amount is lower than the non-facility-based payment amount. During the PHE, CMS encouraged the expansion of telehealth by paying the PFS rate for telehealth services at the higher, non-facility amount.

As part of CMS's telehealth waivers and flexibilities, CMS requires the use of modifier "95" on the claim lines for services furnished via telehealth and requires practitioners to report the POS code that would be applied if the telehealth service had been furnished in person. Alternatively, providers can choose to maintain Medicare's billing practice and to continue to use POS code "02" during the PHE. If CMS reverts to the pre-pandemic policy and pays physicians at the facility-based rate, offering telehealth services will become untenable for AMGA members. The facility-based payment amount is not commensurate with the expenses for offering care to patients via telehealth.

#### **Topic 4B: Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities - Recommendations**

*Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.*

### **FACILITATE CONTINUED CARE ACCESS**

To ensure continued access to vital telehealth services for vulnerable and underserved Medicare beneficiary populations, CMS should continue to pay telehealth services physicians and Non Physician Providers (NPPs) at the higher non-facility amount after the PHE and should not finalize a policy that reimburses providers less to provide patients with the same care that would be provided in a clinician's office. The staffing and resources needed to provide telehealth are not materially different from what is needed for an in-office visit and a lower payment rate will make it challenging for providers to continue to enhance healthcare access to patients through telehealth. Further, in the goal to transform to a value-based care delivery system, the patient perspective is important, and the preference for telehealth access is an important consideration.

Further, it would be reasonable to interpret Section 1834(m)(2)(A) of the Social Security Act to align with the higher facility-based payment amount, given the requirement of statute that payment for services furnished to an eligible telehealth individual should be equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system. As such, AMGA believes that upon the expiration of the PHE, CMS should continue to pay the non-facility-based payment rate to avoid a significant reduction in reimbursement for telehealth, and to continue offering telehealth as an option for Medicare beneficiaries. Payment parity for these services is critical to ensure providers serving rural and underserved communities have sufficient resources to afford greater care access and quality care delivery.

In addition, AMGA strongly recommends that CMS permanently add payment for audio-only services rather than relegate the Telephone evaluation and management (E/M) visit codes to "bundled" status. It is essential that CMS continue to offer separate payment for services to promote continuity of care for beneficiaries requiring these services, particularly in rural geographic regions where video services are not well supported.

In a separate PHE telehealth flexibility, CMS reimbursed physicians for telehealth services provided via audio-only telecommunication systems for specific services, including certain behavioral health, counseling, and educational services. CMS will continue to pay for services furnished via audio-only telecommunications for 151 days after the end of the PHE as required by the Consolidated Appropriations Act of 2022. AMGA is concerned that, under pending CMS regulations, there will be no separate payment for audio-only E/M visits upon the conclusion of the PHE. Rather, CMS will assign these codes to the Telephone E/M visit codes "bundled" payment status.

To learn more about AMGA's comments, contact Darryl Drevna, AMGA's senior director of regulatory affairs at [ddrevna@amga.org](mailto:ddrevna@amga.org).