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October 5, 2020

Ms. Seema Verma, MPH
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW Washington, DC 20201

Re: AHCA Response to Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; et al. Federal Register, Vol. 85, No. 159, Monday, August 17, 2020. CMS–1734–P (RIN 0938–AU10)

Dear Administrator Verma:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,200 long term and post-acute care facilities, or 1.07 million skilled nursing facility (SNF) beds and more than 260,000 assisted living beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living (AL) communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD).

We appreciate the opportunity to comment on the Physician Fee Schedule Proposed Rule for calendar year (CY) 2021. SNFs serve a dual purpose. First, SNFs provide short-term Medicare Part A post-acute services to beneficiaries who require skilled nursing and/or rehabilitation services on an inpatient basis. Additionally, SNF's furnish and bill Medicare Part B under the PFS for long-stay and residents under a Part A stay for services excluded from consolidated billing requirements, as well as for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services for beneficiaries in nursing facilities who are either not eligible for or have exhausted Part A benefits. SNF, along with other types of outpatient therapy providers also furnish Part B therapy services to ambulatory outpatients and AL residents, often to provide follow-up care after a SNF stay.

Long- and short-term SNF, AL, and ID/DD residents have complex health care conditions, comorbidities, and functional deficits requiring ongoing interdisciplinary care. In addition to outpatient therapy payment rates and policies associated with services furnished by PT and OT assistants, our members have a vested interest in assuring that other Part B policies that impact care for residents, including physician, portable x-ray, and telehealth providers, provide adequate and timely access to these necessary services to improve care and reduce unnecessary hospitalizations for emergent conditions that could be better treated in place at a lower cost.

The Association appreciates the efforts of CMS in responding to the COVID-19 public health emergency (PHE) through the issuance of various waivers and other regulatory changes to permit more flexible, effective, and efficient care delivery during this crisis. We are pleased that several of the suggestions we put forth in prior comments submitted in response to the April 6, 2020 CMS COVID-19 Interim Final Rule with Comment (85 FR 19230) are reflected in this proposed rule.

In this comment letter the Association would like to focus on the following key topics discussed in the proposed rule:

- Medicare telehealth and other services involving communication technology
- Refinements to values for outpatient therapy evaluations analogous to office/outpatient E/M visits
- Revised medical record documentation requirements for physical and occupational therapists and speech-language pathologists
- Planned 30-day delayed effective date for the final rule
- Impact of proposed changes in relative value units on SNF, AL, and ID/DD resident access to physician, portable x-ray, outpatient therapy, and other essential services

If you have questions about any of our comments, please contact Daniel Ciolek at dciolek@ahca.org.

Sincerely,

Mark Parkinson
CEO/President

Daniel E Ciolek
Associate Vice President, Therapy Advocacy

Summary of AHCA/NCAL Recommendations

Section II.D. Telehealth and Other Services Involving Communications Technology

Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List (p. 50098)

- We support the proposed designation of the [Physician] Nursing facilities discharge day management codes (CPT codes 99315-99316) as Category 3, temporary addition to the Medicare telehealth services list.
- We oppose the proposal to not extend the telehealth designation at the end of the PHE for several codes. As an alternative, we recommend that the following codes also be added as Category 3, temporary addition to the Medicare telehealth services list. [Physician] Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306); and Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507).

Proposed Provisions Related to Furnishing Telehealth Visits in Nursing Facilities Mandated face-to-face physician visits (p. 50111)

- We support the elimination of the requirement in § 410.78 that restricts physicians and practitioners from using telehealth to furnish the physician visits required under §483.30(c).

SNF Telehealth Visit Frequency Limitations (p. 50111)

- We recommend that CMS permanently remove the SNF telehealth limits for subsequent nursing facility care by a beneficiary's attending physician, or at a minimum reduce the limits so that they are standardized across all post-acute care settings.

Proposed Technical Amendment to Remove References to Specific Technology (p. 50112)

- We support the proposed technical amendments to remove outdated references to specific types of technology and provide a clearer statement of policy

Communication Technology-Based Services (CTBS) (p. 50112)

- We support the CMS proposal to permanently add HCPCS codes G2061, G2062, and G2063 and to create HCPCS codes G02X0 and G02X2 as services that could be furnished via telecommunications technology, but that are not considered Medicare telehealth services, and which can be furnished by non-physician specialties including licensed clinical social workers and clinical psychologists, as well as PTs, OTs, and SLPs.
- We request that CMS clarify in the Final Rule and in sub-regulatory guidance that these services can also be billed when furnished under a PT, OT, or SLP plan of care when

furnished by facility-based providers (i.e. hospitals, SNFs, HHAs, rehabilitation agencies, and CORFs) under the outpatient therapy benefit.

Section II.F. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

Therapy Evaluations (p. 50133)

- We support the CMS proposal to adjust the work RVUs for outpatient therapy evaluations and to consider alternative approaches submitted by stakeholders in future rulemaking that may better reflect the true values.

Section II.G. Scope of Practice and Related Issues

Medical Record Documentation (p. 50148)

- We support the CMS clarification that the broad policy principle that allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists as this will reduce documentation burden without impacting care.

Section V. Planned 30-day Delayed Effective Date for the Final Rule (p. 50336)

- We recognize that the importance of providing appropriate considerate of public comments through a complete 60-day review of such comments supersedes the need to publish the final rule by November 1 to be effective January 1 of the following payment year and supports the proposed approach.

Section VIII.C.1. Regulatory Impact Analysis; Changes in Relative Value Unit (RVU) Impacts; Resource-Based Work, PE, and MP RVUs (p. 50372)

- We urge CMS to consider mitigating the impact of the budget neutrality (BN) provision by taking the following actions:
    1. Exercise its PHE authority to eliminate or mitigate the impact of the proposed BN reduction.
    2. Eliminate the new E/M add-on code (GPC1X).
    3. Consider the negative impact of COVID-19 on 2021 E/M visit utilization projections to calculate the BN adjustment.
    4. Review its BN calculations to ensure that it accurately reflects the E/M billing policies that will become effective in 2021.
    5. Utilize previous over-estimated spending to reduce the BN adjustment.

AHCA/NCAL Detailed Comments

Section II.D. Telehealth and Other Services Involving Communications Technology

Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List (p. 50098)

CMS Proposal:
In response to the public health emergency (PHE) for the COVID–19 pandemic, the Centers for Medicare and Medicaid Services (CMS) undertook emergency rulemaking on March 31, 2020 to temporarily add several services to the Medicare telehealth services list on an interim final basis for the duration of the PHE (85 FR 19234). A number of these services, added as Category 2 telehealth services, on the basis that there was a patient population that would otherwise not have access to clinically appropriate treatment, was extremely beneficial to Medicare beneficiaries residing in American Healthcare Association and National Center for Assisted Living (AHCA/NCAL) member SNF and AL communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD). Among those added telehealth codes most beneficial to our member's residents were:

- [Physician] Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316).
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, and 92507).

In the proposed rule, CMS recognizes that the experiences of clinicians who are furnishing telehealth services during the PHE will be useful to inform decisions about which of the services the Agency added temporarily to the Medicare telehealth services list might be appropriate to add on a permanent basis. Specifically, CMS voiced concern that in the event that the PHE ends prior to the end of calendar year 2021, stakeholders might not have the opportunity to use the current CMS consideration process for telehealth services to request permanent additions to the Medicare telehealth services list prior to those services being removed from the Medicare telehealth services list. Specifically, CMS states:

> *Recognizing the extent to which practice patterns are shifting as a result of the PHE from a model of care based on in-person services to one that relies on a combination of in-person services and virtual care, we believe that it would be disruptive to both clinical practice and beneficiary access to abruptly eliminate Medicare payment for these services when furnished via telehealth as soon as the PHE ends without first providing an opportunity to use information developed during the PHE to support requests for permanent changes to the Medicare telehealth services list*
>
> *… Feedback from patients and clinicians is essential to help CMS understand how the use of telehealth services may have contributed positively to, or negatively affected, the quality of care provided to beneficiaries during the PHE for the COVID-19 pandemic so that we can understand which services should be retained on the Medicare telehealth services list until we can give them full consideration under our established rulemaking process.*
>
> *Therefore, we are proposing to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. This new category would describe services that would be included on the Medicare telehealth services list on a temporary basis. We would include in this category the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria.*

In Table 12 of the proposed rule, CMS summarizes the specific codes the Agency is proposing to make permanent, to assign as a Category 3 telehealth service through the end of the calendar year following the end of the PHE, or to not continue as a telehealth service once the PHE ends. Among these codes most beneficial to short- and long-stay SNF residents, only the physician nursing facility discharge day management code is proposed to be continued temporarily once the COVID-19 PHE ends (See Table 1).

Table 1: Excerpt from Table 12 of the Proposed Rule - CY 2021 Proposals for Addition of Services to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
2. Services we are proposing as Category 3, temporary additions to the Medicare telehealth services list.	• [Physician] Nursing facilities discharge day management (CPT codes 99315-99316)
3. Services we are not proposing to add to the Medicare telehealth services list but are seeking comment on whether they should be added on either a Category 3 basis or permanently.	• [Physician] Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)

AHCA/NCAL Comment:
We appreciate the efforts of CMS during the PHE to temporarily add numerous essential healthcare services to the list of Medicare telehealth services during the current PHE, and that the Agency is soliciting comment on whether to permanently extend this designation after the end of the PHE for specific services, or whether to temporarily extend the designation for some services to gather more information about whether to permanently add such services to the telehealth designation in future rulemaking.

- **We support the proposed designation of the [Physician] Nursing facilities discharge day management codes (CPT codes 99315-99316) as Category 3, temporary addition to the Medicare telehealth services list.**
- **We oppose the proposal to not extend the telehealth designation at the end of the PHE for several codes. As an alternative, we recommend that the following codes also be added as Category 3, temporary addition to the Medicare telehealth services list. [Physician] Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306); and Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507).**

We do not believe that any abrupt disruption in access to telehealth services for physician initial nursing facility visits or outpatient therapy services immediately at the end of the declared PHE is appropriate. The end of a declared PHE does not mean that the public health risks associated with COVID-19 have been eliminated. Individual patients and individual clinicians may still contract this communicable disease that has a high mortality rate among the population of beneficiaries residing in SNF, AL, and ID/DD communities. The temporary extension of furnishing these services as telehealth services, particularly for infection control purposes, will be essential for an unknown period of time following the end of the declared PHE. Additionally, while the PHE was declared in March, CMS did not approve or provide guidance for facility-based outpatient therapy providers until issued in Section MM of the CMS

COVID-19 FAQs on Medicare fee-for-service (FFS) Billing on May 27, 2020[1]. There has been insufficient time for CMS, beneficiaries and providers to fully evaluate the full benefits of appropriately furnished outpatient therapy services furnished via telehealth. The addition of these services to the temporarily Category 3 telehealth list will permit a more thorough analysis.

Proposed Provisions Related to Furnishing Telehealth Visits in Nursing Facilities

Mandated face-to-face physician visits (p. 50111)

CMS Proposal:
The long-term care facility regulations at § 483.30(c) require that residents of SNFs receive an initial visit from a physician, and periodic personal visits subsequently by either a physician or other nonphysician practitioner (NPP). In the CY 2010 PFS final rule with comment period (74 FR 61762) CMS stated that these regulations ensure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay. In that rule CMS stated that the Agency believes that these federally mandated visits should be conducted in-person, and not as Medicare telehealth services. CMS therefore revised § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under §483.30(c).

During the PHE for the COVID-19 pandemic, CMS waived the requirement in 42 CFR 483.30 for physicians and nonphysician practitioners to personally perform required visits for nursing home residents and allowed visits to be conducted via telehealth[2].

In this proposed rule, the Agency is seeking public comment on whether it would be appropriate to maintain this flexibility on a permanent basis outside of the PHE for the COVID-19 pandemic. CMS invites public comment on whether the in-person visit requirement is necessary, or whether two-way, audio/video telecommunications technology would be sufficient in instances when, due to continued exposure risk, workforce capacity, or other factors, the clinician determines an in-person visit is not necessary.

AHCA/NCAL Comment:
We appreciate the flexibilities granted by CMS during the COVID-19 PHE in allowing beneficiaries to access initial and periodic physician services as required in the long term care facility regulations at § 483.30(c) via telehealth in situations where the physician determined in the best interest of the beneficiary and in order to minimize public health risks that the physician services could be safely and effectively furnished via telehealth.

- **We support the elimination of the requirement in § 410.78 that restricts physicians and practitioners from using telehealth to furnish the physician visits required under §483.30(c).**

We believe that the decision as to whether the physician should conduct an in-person visit or whether two-way, audio/video telecommunications technology would be sufficient in instances when, due to continued exposure risk, workforce capacity, or other factors should be left to the physician in consultation with the resident/family and SNF clinicians. Sub-regulatory guidance providing examples of appropriate use of telehealth services for required physician SNF visits should be sufficient to best balance resident care needs when face-to-face encounters are not appropriate or practical.

[1] https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
[2] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

SNF Telehealth Visit Frequency Limitations (p. 50111)

CMS Proposal:
CMS indicates that the Agency has received requests to revise the current frequency limitations for telehealth for subsequent inpatient and nursing facility visits. Currently, CMS limits the provision of subsequent inpatient visits via Medicare telehealth to once every 3 days and subsequent nursing facility visits to once every 30 days. However, during the COVID-19 PHE, this policy was waived to minimize spread of the COVID-19 virus. CMS stated in the April 6, 2020 IFC (85 FR 19230) that given the Agency's assessment that under the PHE for the COVID–19 pandemic, since the SNF patient population would otherwise not have access to clinically appropriate in-person treatment, CMS does not believe these frequency limitations are appropriate or necessary. In this proposed rule, CMS is proposing to revise the frequency limitation for SNF from one visit every 30 days to one visit every 3 days. CMS is seeking comment on whether frequency limitations broadly are burdensome and limit access to necessary care when services are available only through telehealth, and how best to ensure that patients are receiving necessary in-person care.

AHCA/NCAL Comment:
We appreciate the efforts of CMS at improving SNF resident access to telehealth services during the COVID-19 PHE by removing the frequency restrictions for physician/ practitioner subsequent NF visits furnished via Medicare telehealth for the duration of the PHE for the COVID–19 pandemic. This waiver is extremely useful to help reduce the transmission of COVID-19 by removing the arbitrary requirement for the beneficiary's attending physician to see all SNF patients face-to-face for a 30-day period after a prior telehealth visit, regardless of the complexity of the patient status or whether the physician determined the service could be effectively furnished remotely.

This waiver has also been invaluable in improving the timeliness of responding to emergent care needs, particularly in rural and remote locations, and on evenings and weekends where the inability of the attending physician to visit a beneficiary face-to-face in a timely manner may result in a preventable emergency room visit or hospital admission.

- **We recommend that CMS permanently remove the SNF telehealth limits for subsequent nursing facility care by a beneficiary's attending physician, or at a minimum reduce the limits so that they are standardized across all post-acute care settings.**

We believe that the decision to furnish the appropriate amount of subsequent nursing care in person versus via telehealth in the best interest of delivering timely, safe, and effective services to the beneficiary should be made by the physician responsible for such care in consultation with SNF clinicians on a case-by-case basis, following best practice or other sub-regulatory guidance, and not restricted by arbitrary limits. For example, it may be much less disruptive for a SNF resident with dementia that is developing an emergent but non-emergency condition on a night or weekend to receive a telehealth visit with the facility nursing staff supporting the distant site physician examination to determine if any treatment plan changes are necessary – as opposed to automatically sending the resident to the emergency room.

Proposed Technical Amendment to Remove References to Specific Technology (p. 50112)

CMS Proposal:
CMS discusses that the final sentence of regulation at § 410.78(a)(3) prohibits the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services. In the March 31st COVID-19 IFC, CMS added a new § 410.78(a)(3)(i) (and reserved §410.78(a)(3)(ii) for later use) to provide for an exception that removes application of that sentence during the PHE for the COVID-19 pandemic. CMS added the new section on an interim final basis because the Agency believes

that the first sentence of § 410.78(a)(3) adequately describes the technology requirements for an interactive telecommunication system that may be used to furnish a Medicare telehealth service. That sentence defines interactive telecommunication system as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication." CMS was also concerned that the reference to "telephones" in the second sentence of the regulation as impermissible technology could cause confusion in instances where an otherwise eligible device, such as a smart phone, may also be used as a telephone. Because these concerns are not situation- or time-limited to the PHE for COVID-19, CMS is proposing to remove the second sentence of the regulation at § 410.78(a)(3) which specifies that "[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.".

As CMS is proposing to adopt this change on a permanent basis, the agency is also proposing to delete the subparagraphs at § 410.78(a)(3)(i) and 410.78(a)(3)(ii) which will remove outdated references to specific types of technology and provide a clearer statement of policy.

AHCA/NCAL Comment:

- **We support the proposed technical amendments to remove outdated references to specific types of technology and provide a clearer statement of policy**

Communication Technology-Based Services (CTBS) (p. 50112)

CMS Proposal:
In the CY 2019 PFS final rule (84 FR 62796), CMS finalized separate payment for several services that could be furnished via telecommunications technology, but that are not considered Medicare telehealth services.

In the CY 2020 PFS final rule, the Agency finalized separate payment for HCPCS codes G2061 (Qualified nonphysician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes), G2062 (Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes), and G2063 (Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes). In that rule, CMS stated that these codes may be billed by nonphysician practitioners (NPPs) consistent with the definition of their respective benefit category, although the agency did not provide specific examples (84 FR 62796).

In the March 31st COVID-19 IFC (85 FR 19244-19245) CMS established on an interim basis for the duration of the PHE for the COVID-19 pandemic that these services could be billed for example, by licensed clinical social workers and clinical psychologists, as well as PTs, OTs, and SLPs who bill Medicare directly for their services when the service furnished falls within the scope of these practitioner's benefit categories. CMS is proposing to adopt that policy on a permanent basis.
CMS is also proposing to allow billing of other CTBS by certain nonphysician practitioners, consistent with the scope of these practitioners' benefit categories through the creation of two additional HCPCS G codes that can be billed by practitioners who cannot independently bill for E/M services:

- G20X0 (Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24

business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)

- G20X2 (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

CMS is proposing to value these services identically to HCPCS codes G2010 and G2012, respectively. The agency acknowledges that it has been agency policy, in general, to differentially value similar services that are performed by practitioners who can and cannot, respectively, bill independently for E/M services, with higher values for the service performed by practitioners who can independently bill E/M services. However, given the relatively low values for HCPCS codes G2010 and G2012, CMS does not think that there is a significant differential in resource costs to warrant different values, but are seeking comment on whether the Agency should value these services differentially, including potentially increasing the valuation of HCPCS codes G2010 and G2012.

Further, to facilitate billing of the CTBS by therapists, CMS is proposing to designate HCPCS codes G20X0, G20X2, G2061, G2062, and G2063 as "sometimes therapy" services. When billed by a private practice PT, OT, or SLP, the codes would need to include the corresponding GO, GP, or GN therapy modifier to signify that the CTB are furnished as therapy services furnished under an OT, PT, or SLP plan of care.

CMS also notes that in section II.K. of the proposed rule the Agency is proposing for CY 2021 to replace the eVisit G codes with corresponding CPT codes, and that this policy would also apply to those codes.

For all these CTBS, CMS is also making clear that the consent from the patient to receive these services can be documented by auxiliary staff under general supervision, as well as by the billing practitioner. While the Agency continues to believe that beneficiary consent is necessary so that the beneficiary is notified of cost sharing when receiving these services, we do not believe that the timing or manner in which beneficiary consent is acquired should interfere with the provision of one of these services. CMS is retaining the requirement that, in instances when the brief communication technology-based service originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable.

AHCA/NCAL Comment:
We appreciate the waivers granted by CMS during the COVID-19 PHE in allowing beneficiaries to access services for a number of services that could be furnished via telecommunications technology, but that are not considered Medicare telehealth services, when furnished by non-physician specialty clinicians including licensed clinical social workers and clinical psychologists, as well as PTs, OTs, and SLPs. We also appreciate that the CMS proposes to permanently add codes G20X0 and G20X2 to reflect such services furnished by these non-physician specialties as covered services with equivalent payment to similar physician-furnished services.

- **We support the CMS proposal to permanently add HCPCS codes G2061, G2062, and G2063 and to create HCPCS codes G02X0 and G02X2 as services that could be furnished via telecommunications technology, but that are not considered Medicare telehealth services, and which can be furnished by non-physician specialties including licensed clinical social workers and clinical psychologists, as well as PTs, OTs, and SLPs.**

- **We request that CMS clarify in the Final Rule and in sub-regulatory guidance that these services can also be billed when furnished under a PT, OT, or SLP plan of care when furnished by facility-based providers (i.e. hospitals, SNFs, HHAs, rehabilitation agencies, and CORFs) billing using the PFS under the outpatient therapy benefit.**

The COVID-19 pandemic and resulting waivers issued by CMS permitting non-physician clinicians to furnish these services to Medicare beneficiaries when it was clinically appropriate in order to prevent the spread of a deadly infections disease has demonstrated the value of permanently adding these remotely delivered non-telehealth services to the clinical toolbox and we support the proposal.

However, we are concerned that the CMS discussion about how these codes would be identified as "sometimes therapy" for claim coding purposes is problematic. Specifically, the phrase "When billed by a private practice PT, OT, or SLP..." could be misinterpreted that this policy would only apply to office-based therapists in private practice. Per the Medicare Payment Advisory Commission (MedPAC), only 34 percent of Medicare Part B therapy services are furnished by therapists in private practice[3]. We request that CMS clarify that this policy would apply to any PT, OT, or SLP provider of outpatient therapy services paid under the PFS regardless of setting.

Section II.F. Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

Therapy Evaluations (p. 50133)

CMS Proposal:
In the NPRM CMS acknowledges that there are a number of services paid under the PFS that are similar in many respects to the office/outpatient E/M visit code set, but do not specifically include, were not valued to include, and were not necessarily valued relative to, office/outpatient E/M visits. These codes inherently include work associated with assessment and work associated with management, like the work included in the office/outpatient E/M visits, which involve time spent face-to-face assessing and treating the patient. These services include therapy evaluation services. PT, OT, and SLP clinicians who furnish these services are prohibited by CMS from billing E/M services due to the limitations of their Medicare benefit categories. As such, the CPT Editorial Panel has created specific coding to describe the services furnished by these practitioners. Although these services are billed using specific, distinct codes relating to therapy evaluations, the Agency indicates they believe that a significant portion of the overall work in the codes is for assessment and management of patients, as it is for the office/outpatient E/M visit codes.

Therefore, CMS is proposing to adjust the work RVUs for these services based on a broad-based estimate of the overall change in the work associated with assessment and management to mirror the overall increase in the work of the office/outpatient E/M visits. CMS calculated this adjustment based on a volume-weighted average of the increases to the office/outpatient E/M visit work RVUs from CY 2020 to CY 2021.

Specifically, the Agency is proposing to apply that percentage increase, of approximately 28 percent, to the work RVUs for the therapy evaluation service codes (Table 2). CMS believes that it is important to the relativity of the PFS to revalue these services to reflect the overall increase in value associated with spending time assessing and managing patients, as reflected in the changes to work values for the

[3] MedPAC, Outpatient Therapy Services Payment System: payment basics, October 2019.

office/outpatient E/M visits, particularly in recognition of the value of the clinicians' time which is spent treating a growing number of patients with greater needs and multiple medical conditions.

CMS states that that this is not the methodology typically used to value services under the PFS and is seeking comment on potential alternative methodologies or specific values for these services, particularly about whether commenters believe it would be better to develop values using comparator codes from the office/outpatient E/M visit code set, and if so, why.

TABLE 2: Excerpt from Table 21 Current and Proposed Work RVUs for ED Visits, Therapy, and Psychotherapy Services

HCPCS Code	Long Descriptor	Current Work RVU	Proposed Work RVU
97161	Physical therapy evaluation: low complexity … Typically, 20 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97162	Physical therapy evaluation: moderate complexity … Typically, 30 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97163	Physical therapy evaluation: high complexity … Typically, 45 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97164	Re-evaluation of physical therapy established plan of care … Typically, 20 minutes are spent face-to-face with the patient and/or family.	0.75	0.96
97165	Occupational therapy evaluation, low complexity … Typically, 30 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97166	Occupational therapy evaluation, moderate complexity … Typically, 45 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97167	Occupational therapy evaluation, high complexity … Typically, 60 minutes are spent face-to-face with the patient and/or family.	1.2	1.54
97168	Re-evaluation of occupational therapy established plan of care … Typically, 30 minutes are spent face-to-face with the patient and/or family.	0.75	0.96
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	1.75	2.24
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	1.5	1.92
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	3	3.84
92524	Behavioral and qualitative analysis of voice and resonance	1.5	1.92

AHCA/NCAL Comment:

- **We support the CMS proposal to adjust the work RVUs for outpatient therapy evaluations and to consider alternative approaches submitted by stakeholders in future rulemaking that may better reflect the true values.**

Section II.G. Scope of Practice and Related Issues

Medical Record Documentation (p. 50148)

CMS Proposal:
As CMS established in the CY 2020 PFS final rule (84 FR 62681 through 62684), and similarly expressed in the May 1st COVID-19 IFC (85 FR 27556 through 27557), any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather

than re-document, notes in the medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team.

CMS also notes that although there are currently no documentation requirements that would impact payment for PTs, OTs, or SLPs when documentation is added to the medical record by persons other than the therapist, the Agency is responding in this proposed rule to stakeholder requests for clarification. Specifically, CMS is clarifying that the broad policy principle that allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists.

This will help ensure that therapists are able to spend more time furnishing therapy services, including pain management therapies to patients that may minimize the use of opioids and other medications, rather than spending time documenting in the medical record. CMS emphasizes that, while any member of the medical team may enter information into the medical record, only the reporting clinician may review and verify notes made in the record by others for the services the reporting clinician furnishes and bills, and that information entered into the medical record should document that the furnished services are reasonable and necessary.

AHCA/NCAL Comment:

- **We support the CMS clarification that the broad policy principle which allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists as this will reduce documentation burden without impacting care.**

Section V. Planned 30-day Delayed Effective Date for the Final Rule (p. 50336)

CMS Proposal:
CMS states in the NPRM that due to the Agency prioritizing efforts in support of containing and combatting the COVID-19 PHE, and devoting significant resources to that end, the work needed on the PFS payment rule will not be completed in accordance with the usual schedule for this rulemaking, which aims for a publication date of at least 60 days before the start of the fiscal year to which it applies to comply with Medicare statute. CMS notes that up to an additional 30 days may be needed to complete the work needed on this payment rule. The PFS payment rule is necessary to annually review and update the payment systems, and it is critical to ensure that the payment policies for these systems are effective on the first day of the fiscal year to which they are intended to apply.

Therefore, due to CMS prioritizing efforts in support of containing and combatting the COVID-19 PHE, and devoting significant resources to that end, The Agency expects that pursuant to 5 U.S.C. 808(2) that, instead of 60 days, the PFS final rule will be effective 30 days after publication as it would be impracticable and contrary to the public interest for CMS to do otherwise. Accordingly, the Agency expects to provide a 30-day delay in the effective date of the final rule in accordance with the Administrative Procedure Act (5 U.S.C. 553(d)), which ordinarily requires a 60-day delay in the effective date of a final rule from the date of its public availability in the Federal Register, and section 1871(e)(1)(B)(i) of the Act, which generally prohibits a substantive rule from taking effect before the end of the 30-day period beginning on the date of its public availability.

AHCA/NCAL Comment:

- **AHCA/NCAL recognizes that the importance of providing appropriate considerate of public comments through a complete 60-day review of such comments supersedes the need**

to publish the final rule by November 1 to be effective January 1 of the following payment year and supports the proposed approach.

Section VIII.C.1. Regulatory Impact Analysis; Changes in Relative Value Unit (RVU) Impacts; Resource-Based Work, PE, and MP RVUs (p. 50372)

CMS Proposal:
In the CY 2020 PFS Final Rule (84 FR 62568), CMS finalized broad changes related to physician evaluation and management (E/M) services to reduce administrative burden, improve payment rates, and reflect current clinical practice. The health care community supported restructuring and revaluing the office-based E/M codes, which will increase payments for primary care and other office-based services. Unfortunately, by law, any changes to the PFS cannot increase or decrease expenditures by more than $20 million. To comply with this budget neutrality requirement, any increases must, therefore, be offset by corresponding decreases. CMS estimates that the 2021 policies will increase Medicare spending by $10.2 billion, necessitating steep cuts by reducing the Medicare conversion factor from $36.0896 to $32.2605, or a 10.6 percent decrease.

As reflected in Table 90 of the Proposed Rule, payments for common PFS services furnished to residents in our member SNF, AL, and ID/DD residences will be cut nine percent for PT and OT services and 6 percent for portable x-ray services. In addition, the proposed rate tables for individual procedures indicates that SLP services as well as physician E/M services furnished to SNF residents will be cut up to 11 percent[4].

AHCA/NCAL Comment:
We strongly object to the extraordinary budget neutrality (BN) reduction proposed by the CMS (the "proposed CF reduction"). While we support the CPT coding revisions and revaluations of office and outpatient evaluation and management (E/M) services recommended by the AMA/Specialty Society RVS Update Committee (RUC), we strongly oppose the proposed budget neutrality (BN) reduction proffered by CMS for these and other PFS changes proposed for 2021.

Due to age and multiple comorbid conditions, residents of SNFs and long-term care residences, such as AL and ID/DD centers are the most vulnerable population impacted by COVID-19 — with incidence and mortality rates much higher than all other demographics. While more than 80% of this population that are infected successfully survive COVID-19, these patients frequently experience significant loss of weight, strength, mobility, and ability to perform activities of daily living, and enjoy life at a level possible prior to the pandemic. These individuals will often need various and sometimes extensive and long-term therapy to restore their abilities to eat, move about, and perform daily activities as independently as possible. Reduced access to PT, OT, and SLP rehabilitation services resulting from the proposed draconian cuts to PFS payments would result in a lower quality of life for nursing facility residents and higher and costly rates of institutionalization of assisted and senior living residents who are unable to restore functional losses experienced during the acute phase of their COVID-19 illness.

Furthermore, while the PFS payment for office-based E/M codes are due to be increased, the physician payment codes for E/M services furnished to SNF short and long-stay residents as well as portable x-ray services are proposed to be cut dramatically, which will seriously impact beneficiary access to care if these providers decide to no longer care for residents in nursing homes.

[4] See Addendum A rate tables for the Proposed Rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/

In addition to the above, if adopted as proposed, the 2021 Medicare PFS will have other negative impacts on SNF, AL, and ID/DD beneficiary access to multiple specialty services as summarized below:

- Cripple the recovery of the nation's health care system by exacerbating revenue shortfalls that are already jeopardizing the financial viability of physician and non-physician providers furnishing PFS services across the country.
- Reduce access to medically necessary specialty services for those Americans who have delayed seeking specialty treatment due to the fear of contracting COVID-19. Institute a conversion factor that is only slightly more than half of the conversion factor applicable in 1994, adjusted for inflation. The anesthesia conversion factor would drop to a rate that is nearly the same as what was in place in 1991.
- Reduce Medicare payment for services provided in patients' homes (including AL and ID/DD residences), physician offices, non-physician practices, therapy clinics, skilled nursing facilities, hospitals and rehabilitation agencies — at a time when the spread of COVID-19 remains unchecked.
- Decrease lifesaving cancer screening services which now face significant backlogs. For example, screenings for breast cancer were down 90%, which will inevitably result in delays in diagnosis and treatment of this disease.
- Further exacerbate the problems occurring across the country with providers furloughing or cutting staff and an increasing number closing their doors or refusing to furnish services in residential facilities where payments are drastically less than office-based E/M rates. Of great concern is the impact that this will have on access to needed health care services, especially for beneficiaries in rural and underserved areas. Because, in the end, if these detrimental cuts are implemented, those who suffer the most will be patients.
- Implement poorly defined additional payments for complex care, the value of which is already incorporated into the updated E/M codes, which further exacerbates the budget neutrality reduction to the conversion factor.

Additional examples of the impact of the proposed payment rate reduction across multiple specialties in the context of the COVID-19 environment are set forth in the legislative request Fact Sheet located in Attachment A.

Considering the ongoing impact of the pandemic on our ability to meet the needs of our patients, we strongly urge CMS to exercise its administrative discretion to eliminate or substantially mitigate the proposed BN reduction.

Preliminarily, we note that many of our objections to the proposed BN reduction were expressed last year, in response to CMS' proposed finalization of the E/M coding revisions and revaluations. In last year's PFS final rule, CMS provided repeated assurances that the provider community's concerns about the potential budgetary impact of the E/M changes and the community's suggestions for mitigating that impact would be taken into account once the budgetary impact of all proposed 2021 changes was calculated. Despite these assurances, the proposed rule fails to acknowledge the devastating impact of the proposed BN reduction, particularly considering the already extraordinary financial stress placed on the nation's physicians and non-physician practitioners by COVID-19. CMS also fails to consider, nor does the agency address in the proposed rule, any of the numerous suggestions already offered by commenters to mitigate the budgetary impact of these changes in 2021. In fact, the proposed rule modifies the assumptions used to calculate the proposed BN reduction in a manner that exacerbates the budgetary problem noted by commenters last year.[5]

We believe that CMS' failure to acknowledge or address the concerns and recommendations already raised by commenters is inconsistent with the statutory requirement that, in making budget neutrality

[5] The 2021 proposed rule increases the utilization assumptions for GPC1X relative to the CY2020 final rule in a manner that increases the cost of implementing the new code by $800 million.

adjustments, the agency must "consult with the Medicare Payment Advisory Commission and organizations representing physicians."[6] While we are deeply disappointed that CMS has thus far failed to fulfill its statutory consultation obligation or honor its commitment to respond to the health care community's concerns in this regard, we urge the agency to closely collaborate with us moving forward to mitigate the proposed CF reduction.

We understand that CMS believes that the proposed payment rate reduction is mandated by Medicare's BN requirements — section 1848(c)(2)(B)(ii) of the Social Security Act (the "BN provision"). The BN provision requires that relative value unit (RVU) valuation changes that exceed a $20 million threshold must be offset by payment reductions for other PFS services. Of the $10.2 billion in additional spending attributable to changes described in the 2021 Medicare PFS proposed rule, only an estimated $5.6 billion is attributable to E/M service changes adopted last year (CPT codes 99202-99215; 99XXX)). An additional $3.3 billion is attributable to the adoption of the new E/M Office Visit Add-on Code (HCPCS GPC1X) and the remainder to various other spending provisions in the proposed rule. Thus, the modification of E/M coding and valuation finalized last year (CPT 99202-99215; 99XXX) accounts for only slightly more than half of the proposed conversion factor reduction.

CMS has significant administrative discretion in administering the BN provision, and the Administration has the power to mitigate the impact of this provision utilizing funds outside of the PFS under the unique circumstances of the Public Health Emergency (PHE) that is currently in effect.

- **In this context, we urge CMS to consider mitigating the impact of the BN provision by taking the following actions:**

    1. **Exercise its PHE authority to eliminate or mitigate the impact of the proposed BN reduction.** Physicians and other health care professionals continue to face unprecedented public health and economic challenges as the result of the continuing pandemic.[7] Additional reductions in practice revenues could create significant access problems during a continuing public health emergency. We urge the Administration to exercise its considerable discretion to waive the BN provision and eliminate or substantially decrease the proposed BN reduction. In this regard, we note that CMS has, on numerous occasions, waived Medicare statutory provisions based on the Public Health Emergency.

        In addition, we note that the Administration has issued an Executive Order related to the allocation of emergency funds without explicit statutory authorization. To the extent that CMS believes that it does not have the requisite authority to waive application of the BN provision to

[6] Social Security Act, §1848(9c)(2)(B)(iii).

[7] The Medical Group Management Association estimates that 97 percent of practices have experienced a negative financial impact directly or indirectly related to COVID-19, with practices reporting a 55 percent decrease in revenue and a 60 percent decrease in patient volume since the beginning of the spread.[7] Another recent study found that the number of visits to ambulatory practices declined nearly 60 percent between February 1 to April 16 — with larger declines among surgical and procedural specialties.[7] And a recent survey of surgeons found that one-in-three private surgical practices stated that they are already at risk of closing permanently due to the financial strain of the COVID-19 crisis. Data also reflect that 38 percent of physical therapy owners/partners reported that revenue had decreased 76 to 100 percent in the early phases of the pandemic, with another 34 percent reporting declines of 51 to 75 percent.[7] See Medical Group Management Association, COVID-19 Financial Impact on Medical Practices, April 13, 2020, https://www.mgma.com/resources/government-programs/covid-19-financial-impact-on-medical-practices. American Physical Therapy Association, Impact of COVID-19 on the Physical Therapy Profession Report, June 2020. https://www.apta.org/contentassets/15ad5dc898a14d02b8257ab1cdb67f46/impact-of-covid-19-on-physical-therapy-profession.pdf; see also American Physical Therapy Association, Impact of COVID-19 on the Physical Therapy Profession Report, August 2020. https://www.apta.org/contentassets/15ad5dc898a14d02b8257ab1cdb67f46/impact-of-covid-19-on-physical-therapy-profession.pdf

provide relief for the nation's physicians and non-physician practitioners, we urge the Administration to utilize emergency and other fund sources otherwise available to it to redress the proposed Medicare PFS payment reduction.

2. **Eliminate the new E/M add-on code (GPC1X).** Last year, CMS finalized the adoption of an ill-defined and controversial E/M add-on code to reflect visit complexity inherent in certain office/outpatient visits. CMS finalized this code over the objections of numerous commenters and despite commenters' serious concerns about the potential impact of this new code on budget neutrality calculations. In fact, if this code were not implemented, the proposed BN reduction would be reduced by about one- third. Moreover, due to the lack of specificity in the code descriptor for this service, CMS' BN calculations assume that the code will be billed whenever any E/M or outpatient visit is performed by virtually any medical specialty. Evidently, the CMS actuaries project that the code could be billed even for the most straightforward follow-up visit for a cold. There can be no clearer evidence that the code descriptor is not sufficiently specific. Furthermore, this add-on code is arguably entirely unnecessary, given how the E/M codes were restructured and valued.

   Importantly, the premature adoption of GPC1X for payment purposes not only will create open-ended liability for the Medicare Trust Fund but also will increase aggregate beneficiary copayments. Adopting the code in its current form has the potential to increase Medicare payment for the most performed E/M services. At the very least, we strongly urge CMS to refer this add-on code to the CPT and RUC processes for review and refinement rather than implementing it this year. If CMS is unwilling to delay implementation of the code, we request that it be implemented on a "no-pay" basis in 2021, so that reliable utilization data can be collected for use in future BN calculations.

3. **Consider the negative impact of COVID-19 on 2021 E/M visit utilization projections to calculate the BN adjustment.** The BN provision requires that CMS make such adjustments as may be necessary to ensure that Medicare expenditures for Part B services do not exceed the amount that would be paid absent RVU changes. As a result of the pandemic, physicians and non-physician practitioners throughout the country ceased providing non-essential medical and surgical services, as directed by federal and state governmental authorities. At this stage, while some areas are reopening and experiencing a surge in pent-up demand for medically necessary services, due to the continued impact of the pandemic, overall patient utilization of E/M visits remains suppressed. One recent study published by the Commonwealth Fund finds: *The number of visits to ambulatory practices fell nearly 60 percent by early April before rebounding through mid-June. From then through the end of July, weekly visits plateaued at 10 percent below the pre-pandemic baseline. The cumulative number of lost visits since mid-March remains substantial and continues to grow.*[8]

   The same study indicates that the number of Medicare visits remains 8 percent below the March baseline. In calculating the BN adjustment, we urge CMS to consider the impact of the pandemic on the utilization of E/M services, and, specifically, to assume a continued reduction of at least 8 percent in the utilization of these services in 2021. Utilizing updated E/M utilization projections that are more likely to accurately reflect the continued impact of COVID-19 has the potential to significantly reduce the impact of the BN adjustment.

[8] The Commonwealth Fund, "The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots August 13, 2020 https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest.

Alternatively, we urge CMS to utilize a base period more recent to 2019 to calculate the BN adjustment. We understand that CMS has already conducted an internal analysis of Medicare fee-for-service claims from March 17 to June 13, which captures pandemic-related utilization changes. The use of this and other 2020 data as the base period to calculate the BN adjustment may have the potential to significantly reduce the BN adjustment and mitigate or eliminate a devastating reduction in Medicare PFS payments.

Likewise, we believe it likely that the mix of E/M services provided to Medicare beneficiaries has shifted as the result of the pandemic. In the May 8 COVID-19 interim final rule with comment period (85 FR 27604-27605), CMS finalized on an interim basis a policy under which both physicians and non-physician practitioners may use CPT code 99211 to bill for services furnished incident to their professional services, for both new and established patients, when clinical staff assess symptoms and collect specimens for purposes of COVID–19 testing, if the billing practitioner does not also furnish a higher-level E/M service to the patient on the same day. CMS is soliciting comments on whether this policy should be made permanent. To the extent that E/M utilization has shifted towards using this code for new or established patients, there may be a reduction in the BN adjustment.

In short, we strongly urge CMS to exercise its considerable statutory discretion to either (a) reduce the overall projected utilization of E/M services by at least 8 percent to reflect the drop in visits resulting from the continuing pandemic or (b) utilize a base period that reflects the reduced utilization of physicians' services resulting from COVID-19. We also request that CMS consider any data suggesting that the pandemic has resulted in a shift toward less intensive E/M services. Such actions have the potential to significantly mitigate the BN adjustment and to avert catastrophic PFS payment reductions.

4. **Review its BN calculations to ensure that it accurately reflects the E/M billing policies that will become effective in 2021.** For example, in last year's Medicare PFS final rule, CMS finalized a policy under which CPT codes 99358–99359 will not be payable in association with office/outpatient E/M visits beginning in CY 2021. Yet, the "CY 2019 Utilization Data Crosswalk to CY 2021" published in conjunction with the proposed rule includes 214,065 "undiscounted claims" for these services, suggesting that the proposed rule's BN calculation does not reflect this policy decision[9]. We urge CMS to examine its BN calculations to ensure that any services that will not be billable in 2021 are not included in the calculation.

5. **Utilize previous over-estimated spending to reduce the BN adjustment.** Under the previous administration, CMS based the 2013 budget neutrality offset for Transitional Care Management on a significantly greater estimate of initial utilization of the service than occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and was still less than one million after 3 years of implementation. For 2013, the Obama Administration reduced Medicare physician fee schedule spending by more than $700 million based on its overestimate of TCM utilization. Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," the statute allows CMS to account for past overestimates of spending when applying budget neutrality. **Accordingly, CMS could lessen the impact of the budget neutrality adjustment for the office visit increases in 2021 by restoring the over-estimated budget neutrality adjustment from the first few years of TCM.**

[9] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/

It is counter-intuitive to put forth drastic reductions to reimbursement at a time when both Congress and HHS are focused on engaging patients, increasing the delivery of integrated, team-based care, expanding chronic disease management, and reducing hospital admission/readmission rates for beneficiaries residing in the community as well as those in long-term nursing facilities. CMS must recognize how the reimbursement reductions for our providers fail to align with CMS' efforts to drive better patient access to care and management.

Attachment A

Congress Must Act to Halt Medicare Payment Cuts and Avoid Further Damage to the U.S. Health Care System

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) issued its long-awaited 2021 Medicare Physician Fee Schedule (PFS) proposed rule. Physicians and nonphysician health care professionals across the United States are now bracing for harmful payment cuts that could jeopardize patient access to medically necessary services. The reductions are primarily driven by new Medicare payment policies for office and outpatient visits that CMS will implement on January 1, 2021. Drastic cuts caused by changes to these visit codes — also known as evaluation and management (E/M) codes — will further strain a health care system that is already stressed by the COVID-19 pandemic. Furthermore, primary care providers will have fewer choices when referring patients to specialists if health care professionals must close or limit their practices as a result of these cuts.

> **LEGISLATIVE REQUEST**: **To help fortify the health care delivery system and ensure the long-term recovery post-pandemic, Congress should pass legislation before January 1, 2021, that holds health care professionals harmless from any cuts related to CMS' E/M proposals.** This much-needed action by Congress, for inclusion in any forthcoming legislative package, will provide a critical reprieve for a broad scope of health care professionals facing substantial payment reductions in the coming months.

BACKGROUND

In 2019, CMS finalized broad changes related to E/M services to reduce administrative burden, improve payment rates, and reflect current clinical practice. The health care community supported restructuring and revaluing the office-based E/M codes, which will increase payments for primary care and other office-based services. Unfortunately, by law, any changes to the PFS cannot increase or decrease expenditures by more than $20 million. To comply with this budget neutrality requirement, any increases must, therefore, be offset by corresponding decreases. CMS estimates that the 2021 policies will increase Medicare spending by $10.2 billion, necessitating steep cuts by reducing the Medicare conversion factor from $36.0896 to $32.2605, or a 10.6 percent decrease.

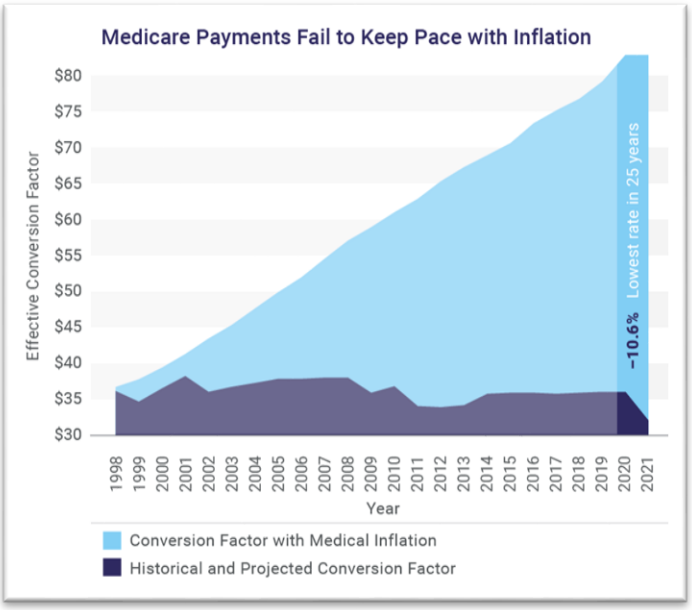
MEDICARE CUTS WILL HURT PATIENTS

As the following table demonstrates, the impact of these cuts are devastating to health care professionals, their practices, and most importantly, their patients:

Specialty	Payment Change	Specialty	Payment Change
Nurse Anesthetist	-11%	Ophthalmology	-6%
Radiology	-11%	Portable X-Ray Supplier	-6%
Chiropractic	-10%	Radiation Oncology	-6%
Cardiac Surgery	-9%	Colon And Rectal Surgery	-5%
Interventional Radiology	-9%	Dietitian Nutritionist	-5%
Pathology	-9%	Gastroenterology	-5%
Physical/Occupational Therapy*	-9%	Independent Laboratory	-5%
Anesthesiology	-8%	Optometry	-5%
Critical Care	-8%	Oral/Maxillofacial Surgery	-5%
Nuclear Medicine	-8%	Orthopedic Surgery	-5%
Thoracic Surgery	-8%	Multispecialty Clinic	-4%
Audiologist	-7%	Infectious Disease	-4%
General Surgery	-7%	Hand Surgery	-3%
Neurosurgery	-7%	Physical Medicine	-3%
Plastic Surgery	-7%	Dermatology	-2%
Vascular Surgery	-7%	Podiatry	-1%
Emergency Medicine	-6%		

Data from Table 90: Proposed CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty
**This category includes Speech-Language Pathology.*

Compounding the problem is the fact that Medicare payments have failed to keep up with inflation since the inception of the PFS in 1992. This decrease in the 2021 conversion factor will be below the 1994 conversion factor of $32.9050 — which is worth approximately $58.02 today![1]



Even before the CMS cuts take effect, health care practices are already in distress due to the pandemic.

- According to a recent survey of surgeons,[2] one-in-three private surgical practices stated that they are already at risk of closing permanently due to the financial strain of the COVID-19 crisis. Many face difficult financial decisions and are responding by either cutting their pay, taking on debt, or laying off or furloughing employees.
- Additional surveys and claims analyses verify that COVID-19 reduced patient volume significantly and has resulted in substantial revenue losses for independent physician practices. Estimates of revenue losses range between 48% and 64% between March and May 2020.[3]
- While visit numbers have rebounded, they are still substantially lower than before the U.S. pandemic began. Over the past three months, forgone visits have created "cumulative deficits" in both patient treatment and practice revenue. The cumulative decline in visits from the start of the pandemic is greatest among specialties like ophthalmology (-47%), dermatology (-42%), surgery (-41%), cardiology (-40%), orthopaedic surgery -39%), and obstetrics and gynecology (-28%).[4]
- It is not just physician practices in distress. Data also reflect that 38% of physical therapy (PT) owners/partners reported that revenue had decreased 76% to 100% in the early phases of the pandemic, with another 34% reporting declines of 51% to 75%.[5] Sixty-four percent saw fewer patients via direct access visits, and 88% reported a drop-off in physician referrals.

COVID-19 AMPLIFIES THE NEED FOR SWIFT CONGRESSIONAL ACTION

Health care professionals across the spectrum are reeling from the effects of the COVID-19 emergency as they continue to serve patients during this global pandemic. Consider the following:

- **Anesthesiologists** have been on the front lines of providing anesthesia and critical care services to Medicare patients infected by COVID-19. This care frequently involves high-risk intubation and

[1] Using the U.S. Bureau of Labor Statistics inflation calculator, the conversion factor in 1994, $32.9050, is worth approximately $58.02 today. This means that the proposed CY 2021 cut of the conversion factor to $32.2605 is an even steeper cut when adjusted for inflation and is by far the lowest conversion factor since its inception in 1992. https://www.bls.gov/data/inflation_calculator.htm.

[2] Survey conducted by the independent public opinion research firm, Brunswick Insight. The online survey of 5,244 surgeons was conducted between May 11-20, 2020. https://www.surgicalcare.org/wp-content/uploads/2020/06/SCC_Member_Survey_Data_06172020_FINAL.pdf.

[3] Fair Health, Healthcare Professionals and the Impact of COVID-19; MGMA, COVID-19 Financial Impact on Medical Practices; AMGA, Surveys of Financial Impact of COVID-19; Primary Care Collaborative, Primary Care & COVID-19 Surveys. http://ndpanalytics.squarespace.com/the-impact-of-covid-19-on-independent-physician-practices.

[4] The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices Are Adapting to the New Normal. Commonwealth Fund (June 2020). https://www.commonwealthfund.org/publications/2020/jun/impact-covid-19-pandemic-outpatient-visits-practices-adapting-new-normal.

[5] Impact of COVID-19 on the Physical Therapy Profession Report: A Report from the American Physical Therapy Profession (June 2020). https://www.apta.org/contentassets/15ad5dc898a14d02b8257ab1cdb67f46/impact-of-covid-19-on-physical-therapy-profession.pdf

extubation services — services that produce the highly infectious aerosolized form of the COVID virus. The projected 2021 payment cuts, on top of already low Medicare payments rates, will further weaken the practices of physician anesthesiologists involved in caring for critically ill patients.

- **Audiologists** play a critical role in the assessment and treatment of hearing loss and balance disorders that include those induced by viruses. Recent studies have indicated that individuals with COVID-19, including those who are asymptomatic, may experience damage to hair cells in the inner ear that can impair hearing function. Although research in this area is emerging as this novel coronavirus continues to spread, there is a growing need for Medicare beneficiaries — one of our most at-risk populations for COVID-19 — to have access to care provided by audiologists, both for COVID-19 and non-COVID-19-related hearing and balance-related problems.

- Extracorporeal membrane oxygenation (ECMO) is the treatment of last resort when COVID-19 patients fail to recover with ventilator support. A **cardiothoracic surgeon** hooks the patient up to a machine that either/both breathes and pumps blood, giving the patient's body a chance to rest and recover under the supervision of cardiothoracic surgeons and other health professionals trained in this specialized treatment. Cardiothoracic surgeons treat patients affected by three of four leading causes of death in the United States: heart disease, cancer (lung and bronchus), and chronic lower respiratory disease. Medicare reimbursement cuts could hinder patient access to life-saving care for these diseases.

- **Certified registered nurse anesthetists** (CRNAs) comprise over 50 percent of the U.S. anesthesia workforce and are expert clinicians with highly specialized skills that they have been providing since the COVID-19 pandemic such as airway management, ventilator support, vascular volume resuscitation, and advanced patient assessment. The truth remains that CRNAs who do not frequently bill for outpatient evaluation and management procedures will see a cut in Medicare payment and that these decreases could impact a typical CRNA's payment by up to 11 percent.

- Doctors of **chiropractic** (DCs) are primary-contact healthcare providers who deliver essential care, including the management of acute and urgent musculoskeletal conditions like neck and low back pain. DCs are educated and licensed to diagnose, treat and co-manage patients and they work in private practices, multi-disciplinary clinics and hospitals across the country. Throughout the COVID-19 pandemic, DCs have continued to treat patients who may otherwise seek emergency care, helping to lessen the strain on frontline providers.

- **Dermatology** practices that perform fewer office E/M services will be especially hit hard, including those practices that provide dermatologic surgical care and dermatopathology practices. Reductions for these practices will be between 6% and 8% in 2021 and are in addition to the negative financial impact of COVID-19 where nine in ten dermatologists have reported losing more than half their income due to the public health emergency, as well as the increased cost of operating in this environment that disproportionately impacts physician doing medical procedures.

- Seniors with diet-related conditions, including diabetes and chronic kidney disease, are suffering from the worst COVID-19 outcomes, including higher rates of death. Medical nutrition therapy provided by registered **dietitian nutritionists** has been proven to help these patients control their blood sugar, blood pressure and weight, slow the progression of diabetes and kidney disease, lower medication use, and avoid unnecessary emergency room visits and hospitalizations.

- Emergency departments (ED) across the U.S. continue to bear the brunt of the COVID-19 pandemic — **emergency physicians** in COVID-19 hotspots have worked tirelessly, often without sufficient personal protective equipment needed to keep them safe, as their EDs are overwhelmed with patients in desperate need of lifesaving care. In other cases, patient volumes have decreased by more than 40 percent (and as much as 60 percent) as patients defer necessary emergency care or avoid the ED altogether due to concerns about contracting the coronavirus. Further exacerbating the financial burden, most emergency physicians have received little if any financial relief under the CARES Act Provider Relief Fund, which has

mainly been distributed to hospitals and not directly to emergency physician groups (it is estimated that emergency physician practices have received only 7 to 15 percent of what they need to make up for lost revenues and increased expenses due to COVID-19).

- Throughout the pandemic, **facial plastic surgeons** have assumed — at considerable personal health risk, with some developing COVID-19 as a result — various roles in assisting other physicians and medical professionals on the front lines in triaging and treating patients impacted by the novel coronavirus. Most facial plastic surgeons — and their staffs — throughout the country are experiencing extreme financial hardships, as a result of shutting down their medical practices and suspending elective surgeries in a proactive effort to dramatically curb the transmission of the virus, safeguard PPE supplies, and promote the public safety and wellbeing of their communities. Additionally, facial plastic surgeons have developed and are implementing guidance on the resumption of elective facial plastic surgical procedures to maximize safety and reduce the risk of COVID-19 transmission as states and their medical practices re-open.

- **Gastroenterology** practices are slowly re-opening and treating more patients after many states and Medicare placed a moratorium on elective endoscopy procedures earlier this year. GI practices were forced to shut down, leading to delays in needed care, including serious delays in colon cancer detection. At a time when practices are safely resuming care, CMS has now proposed deep cuts to these very GI services. Congress must step in and prevent these looming Medicare cuts.

- **Hand surgeons** across the country had the majority of their revenue deeply cut when their elective office patient flow and surgical cases were canceled to preserve personal protective equipment (PPE) and due to fear of spreading the virus to crucial medical personnel. While emergent hand patients were treated surgically, this resulted in exposure to undiagnosed COVID-19. The severe revenue loss resulted in furloughs and layoffs of office staff, causing access to care challenges for patients.

- In many hospitals, **interventional radiology** (IR) was one of the few services that has remained open throughout the pandemic, providing emergency care to COVID-19 patients. IR services have included dialysis catheters and other venous access; drainage procedures such as abscess and cholecystectomy; and lysis procedures for COVID-19 patients with massive embolism and deep vein thrombosis. Nevertheless, canceled elective cases, the need for PPE, increased risks of caring for patients with COVID-19, staff reassignments — including technicians, nurses and physician— and private practices unable open while maintaining staff and benefits, has resulted in lost revenue, significant burnout and stress.

- **Neurosurgeons** are stepping up to lend their expertise on the frontlines of the COVID-19 pandemic, as well as continuing to take care of critically ill patients who suffer from painful and life-threatening neurologic conditions such as traumatic brain injury, brain tumors, debilitating, degenerative spine disorders, and stroke. Without timely neurosurgical care, patients can face permanent neurologic damage or death.

- Many **obstetrician-gynecologists** exclusively provide gynecologic services and were required to cancel all non-urgent procedures and office visits in the spring, reducing their practice revenues to almost nothing. For those ob-gyns that provide obstetric and gynecologic services, gynecologic services are essential to maintaining financial solvency due to inadequate reimbursement rates for obstetric care. The forthcoming cuts to gynecologic surgery — which average 7.4% — will be detrimental to ob-gyns who are already facing financial hardships and will put the future of private practice in jeopardy.

- **Occupational therapy** (OT) practitioners are working with patients across health care settings to promote recovery from the functional effects of COVID-19. These effects include COVID-19-related cognitive impairments, neuromuscular damage, fatigue, and psycho-social challenges — all of which interfere with one's ability to participate safely in necessary and meaningful day-to-day activities. OT services are crucial to achieving optimal function and long-term rehabilitation/recovery for people with COVID-19.

- **Ophthalmology** lost more patient volume due to the COVID-19 pandemic than any other medical specialty. Many practices were forced to furlough or lay off staff. Despite the challenges, ophthalmologists continue to treat patients with chronic conditions, such as glaucoma and macular degeneration, in addition to eye emergencies, retinal tears and detachments, eye strokes, eye infections, trauma, and cancer that can cause scarring, permanent damage or complete vision loss. Ophthalmologists are struggling to return to "normal" — working to rehire staff, if they're still available, managing a backlog of delayed care and instituting costly new safety procedures to protect their patients and staff from the virus. The proposed 6 percent Medicare pay cut for 2021 also doesn't tell the whole story. Cataract surgery faces a 9% reduction after experiencing a 15% reduction in 2020. Retina and glaucoma procedures are also facing 9% to 10% reductions in 2021. Ophthalmology practices — especially small private practices — that are still struggling to recover from the COVID-19 pandemic will be devastated by these substantial payment cuts. Our already weakened health care system can't take anymore.

- **Orthopaedic surgery** practices have stepped up throughout the COVID-19 pandemic, abstaining from elective surgery to preserve life-saving PPE. Practices are now working against significant patient backlogs and are struggling to catch-up working with limits on operating room time and, in many cases, with a reduced staff. Orthopaedic surgeons are now facing Medicare payment cuts for total hip arthroplasty and total knee arthroplasty, on top of the proposed E/M cuts. This double reduction will result in Medicare payment cuts of up to 10% for these procedures, and if not quickly addressed by CMS, access to musculoskeletal care will be significantly threatened.

- **Pathologists** are integrally involved in direct mitigation of the COVID-19 crisis, including testing for accurate and timely diagnosis and potential cures. These cuts will have a significant impact on pathology at a time when patients and their treating physicians are relying on the expertise of pathologists. There are still challenges in increasing COVID testing and supply chain management. When you combined those critical issues with 9% cuts pathologists are facing next year, it will have a devastating impact on practices, and ultimately patient care.

- Once patients recover from COVID-19 symptoms, their journey is not over. Hospitalization and bed rest can lead to complications of the musculoskeletal system, including strength loss, atrophy and contracture, as well as be devastating to the cardiopulmonary system. **Physical therapists** (PT) and physical therapist assistants are providing rehabilitation to patients with muscle weakness and limitations in strength and function due to their ICU stay, as well as cardiac rehabilitation, to help patients recover.

- Although the pandemic has changed the way many board certified **plastic surgeons** practice, it has also provided a call to action that the specialty, as it has during so many crises, continues to answer. Beginning in March plastic surgeons worked directly with the White House COVID-19 Task Force, Federal Emergency Management Agency and the National Safety Council. Rallying members and using connections to industry and suppliers, plastic surgeons donated five million NIOSH certified N95 masks; one million FDA certified N95 masks; and 20,000 surgical masks. They also created a national clearinghouse where plastic surgeons offered to donate ventilators to hospitals in short supply. From donating desperately needed medical and personal protective equipment to coordinating hospital logistics to handle surges of patients to finding new ways to consult and follow-up with patients, plastic surgeons continue to go above and beyond to help each other, their communities and countless others through this unique moment in history. Plastic surgeons also developed a broad range of resources to provide guidance to ensure patients continue to receive the reconstructive care they need.

- **Psychologists** are Medicare's primary providers of mental and behavioral health services, diagnostic services, and psychological and neuropsychological tests and assessments. The COVID-19 public health emergency is taking a heavy toll on the mental health of Medicare beneficiaries and all Americans. According to June data from the Kaiser Family Foundation, more than one-third of U.S. adults reported

symptoms of anxiety or depressive disorder, more than three times the number in 2019. Based on the consequences of previous epidemics, experts predict that the mental health impacts from COVID-19 will continue well after the end of the public health emergency.

- Medicare's proposed 6% E/M cut for **radiation oncology** rubs salt in the open wound for radiation therapy clinics, as most struggle with revenue declines of 20-30% or more due to COVID-19. The National Cancer Institute predicts that COVID-19 will lead more patients to present with later-stage cancer, requiring radiation oncology physicians to treat more challenging cases with fewer resources unless Congress stops the E/M cuts.

- Particularly in areas where COVID-19 testing kits are not widely available, medical imaging is used to help confirm COVID-19 findings, gauge the extent of illness and determine effective treatment. As **radiology** practices followed WHO and CDC guidance to postpone non-urgent care, and Americans worried about infection risk, cancer screenings — including mammograms — and other oncologic imaging plummeted. Major cancer diagnoses are down 46 percent. Seventy percent of radiology practices had to take out small business loans or federal relief options to survive the pandemic's financial toll. Drastic imaging cuts now may drive practices out of business, restrict access to care and cause a spike in adverse health outcomes — including deaths.

- **Social Workers** with clinical licensure (LCSWs) provide assessment, diagnostic and psychotherapy services for children, adolescents, adults, couples, families and groups. As the largest group of mental health professionals in the country (over 250,000 practitioners), LCSWs work in a broad range of settings. LCSWs also assess and provide resources for the Social Determinants of Health (SDOH), e.g., housing, income, health care, nutrition, etc. The exponential increase in panic and hopelessness experienced by Medicare beneficiaries, in particular, is leading to a higher rate of suicidality, especially in people of color, according to the Centers for Disease Control and Prevention. It should be noted that LCSWs are currently being reimbursed at a rate that is 25% less than other Medicare mental health providers for the very same services. Thus, the additional 6% cut to reimbursement will make it difficult for CSWs to continue providing services to Medicare beneficiaries.

- **Speech-language pathologists** (SLPs) provide critical speech, swallowing, and cognitive care to individuals with COVID-19 — especially those who currently are, or have been, intubated as a result of the need for mechanical ventilation. SLPs help facilitate communication between these patients and their other providers through a variety of ways to improve patient care and treatment outcomes, and provide essential speech and swallowing therapy post-intubation. Some patients who have been intubated or have received low oxygen to the brain during the COVID-19 episode may also have persistent cognitive issues (e.g., memory impairments). As part of the patient's healthcare team, SLPs can help the individual lead a more independent life to reduce adverse outcomes such as rehospitalizations and reduce health care costs.

- Due to age and multiple comorbid conditions, residents of **skilled nursing** and **long term care facilities**, such as assisted living, are the most vulnerable population impacted by COVID-19 — with incidence and mortality rates much higher than all other demographics. While more than 80% of this population that is infected successfully survives COVID-19, these patients frequently experience significant loss of weight, strength, mobility, and ability to perform activities of daily living, and enjoy life at a level possible prior to the pandemic. These individuals will often need various and sometimes extensive and long-term therapy to restore their abilities to eat, move about, and perform daily activities as independently as possible. Reduced access to PT, OT, and SLP rehabilitation services resulting from the proposed draconian cuts to PFS payments would result in a lower quality of life for nursing facility residents and higher and costly rates of institutionalization of assisted and senior living residents who are unable to restore functional losses experienced during the acute phase of their COVID-19 illness.

- **Surgeons** have continued to operate on patients in need of critically important procedures during COVID-19 that saved lives and improved patients' quality of life. Many surgeons have served on the frontlines of the pandemic, helping the sickest patients fight COVID-19 and treating non-surgical patients who have contracted the disease.

BOTTOM-LINE

The health care community appreciates CMS' efforts to restructure and revalue the office-based E/M codes. However, we are deeply concerned that adhering to existing budget neutrality requirements for implementing the new policy will do lasting damage to the health care system — particularly in light of the COVID-19 crisis. **As such, Congress should pass legislation to hold health care professionals harmless from cuts associated with the finalized E/M code policies slated for implementation on January 1, 2021.**

Congress must act now to prevent these cuts from going into effect!