



October 1, 2020

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P)

Dear Administrator Verma:

On behalf of the Heart Failure Society of America (HFSA), I am writing to provide input on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2021 Medicare Physician Fee Schedule. The vision of the Heart Failure Society of America is to significantly reduce the burden of heart failure. HFSA is a multidisciplinary organization working to improve and expand heart failure care through collaboration, education, research, innovation, and advocacy. We appreciate the opportunity to comment on this proposed rule.

Determination of Practice Expense (PE) RVUs: Indirect PE per Hour Data for PT/INR Remote Monitoring

CMS recognizes and reimburses for Prothrombin Time and International Normalized Ratio (PT/INR) remote monitoring services using the following G-codes:

- G0248 (*Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use*)
- G0249 (*Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week*)



HFSA is concerned about the ongoing undervaluation of these services by the MPFS. In this year's proposed rule, CMS recognizes stakeholder concerns about the reimbursements for these services and identified concerns regarding the appropriate specialty crosswalk used for home PT/INR monitoring services and that the current crosswalk does not reflect the indirect costs associated with furnishing these services.

HFSA urges CMS to update its indirect PE calculations for PT/INR remote monitoring services in the CY 2021 final rule to address the insufficient reimbursements for these services. We are concerned about the ability of suppliers to continue to provide these services. Lack of access to these services will result in harm to patient outcomes, increased emergency department utilization, and increased hospitalizations. CMS must seek to establish a PE methodology for PT/INR remote monitoring services that more accurately reflects the costs of providing these services.

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

Office and Outpatient E/M Policies

As we have stated to CMS in response to previous rulemaking when the Agency developed its CY 2021 policies for office and outpatient E/M services, the HFSA supports the CMS' finalized policy to revise E/M coding consistent with the framework supported by the AMA CPT Editorial Panel. This includes the revisions to the times and medical decision-making documentation guidelines and the new policy that performance of history and exam is required only as medically appropriate.

CMS also previously finalized adoptions of the AMA RUC-recommended values for the office/outpatient E/M visit codes and a new add-on CPT code for prolonged service time, as well as a Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. As we stated before, we commend CMS for its efforts to recognize the additional work related to a patient's single, serious or complex chronic condition.

However, HFSA is concerned about the impact that these policies will have resulted in a proposed - 10.6% reduction to the CY 2021 Medicare Physician Fee Schedule at the exact moment that we are grappling with the ongoing COVID-19 public health emergency (PHE). Therefore, HFSA requests that CMS work with HHS to use the authorities granted under the PHE declaration to waive budget neutrality given the negative impacts that this cut will have across the fee schedule during a national health crisis that will have lasting impacts even beyond the moment in time when the PHE declaration is rescinded. In addition, we implore CMS to work with Congress to address these cuts before the slated January 1, 2021 implementation date.

CMS also signals its intention to move forward with the implementation of the office and outpatient E/M complexity code, GPC1X (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and*

management visit, new or established). However, the Agency also solicits comments given that a number of stakeholders have requested clarification around utilization of the code and confusion about its proper use. HFSA concurs with the request made by the American College of Cardiology (ACC) to postpone the implementation of GPC1X, particularly given the \$3.3 billion worth of spending associated with the code that results in a 3.5% reduction to the CY 2021 MPFS conversion factor.

Proposed Increases to Transitional Care Management (TCM) Services Based on Increases to Office and Outpatient E/Ms

CMS has previously recognized the following codes describing TCM services:

- CPT 99495 (*Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver with 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge*)
- CPT 99496 (*Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver with 2 business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge*)

In this year's rule, CMS notes that these codes were partially valued based on a relationship to office and outpatient E/Ms. Specifically, CPT 99495 was valued with one level 5 office and outpatient established patient visit and CPT 99496 was valued with one level 5 office and outpatient established patient visit. Therefore, given the increases in those office and outpatient visit codes, CMS proposes to:

- Increase CPT 99495 from 2.36 wRVUs to 2.78 wRVUs
- Increase CPT 99496 from 3.10 wRVUs to 3.74 wRVUs

The HFSA is supportive of the increases to TCM services based on their relationship to the office and outpatient E/Mcodes. HFSA has long discussed the need for TCM services and the important role such services fill to improve outcomes for Medicare beneficiaries, particularly important for patients with heart failure.

We would, however, note several discrepancies in the rule itself and the referenced addendum.

- CPT 99494: Table 19 in the proposed rule is missing the increased proposed value. In the proposed rule Addendum, CMS states that the proposed wRVUs for CPT 99494 are 2.78 wRVUs.
- CPT 99495: In Table 19 in the proposed rule, CMS states that the proposed increase to CPT 99494 is 3.74 wRVUs; however, in the Addendum, CMS lists the proposed CY 2021 wRVU as 3.79.

We urge CMS to provide clarification in the final rule.

Valuation of Specific Codes: Ventricular Assist Device (VAD) Interrogation (CPT code 93750)

CMS proposes a CY 2021 work RVU for CPT 93750 (*Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report*) of 0.75, over 11% less than the RUC-recommend value of 0.85.

HFSA supports the comments of the American College of Cardiology (ACC), and we urge CMS to implement the RUC-recommended value of 0.85. In particular, we echo ACC's comment that, while both the ICD and VAD patients are ill, the VAD patients have heart failure that has deteriorated to such a degree that a pump has been inserted into their chest to support their heart while they await a transplant or to improve the quality of their remaining life. The underlying illness is different, and the RUC-recommended, slightly higher crosswalk appropriately recognizes that difference. Therefore, HFSA urges CMS to finalize the RUC-recommended work value of 0.85 for CPT 93750.

Payment for Principal Care Management (PCM) Services in Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

In CY 2020 rulemaking, CMS finalized a series of proposals to support PCM to pay physicians for providing care management to patients with a single high-risk disease (as differentiated from the current chronic care management codes require patients to have two or more chronic conditions). CMS had stated that PCM services would include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional. CMS finalized a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record. In addition, CMS clarified PCM services should not be furnished with other care management services by the same practitioner for the same beneficiary, nor should PCM services be furnished at the same time as interprofessional consultations for the same condition by the same practitioner for the same patient.

In CY 2021 rulemaking, CMS proposes extending the ability to furnish and bill for PCM services to RHCs and FQHCs using G0511, either alone or with other payable services on an RHC or FQHC claim for dates of service on or after January 1, 2021. As we did in the initial implementation of the PCM codes, the HFSA is extremely appreciative of CMS for its recognition of the need for care management by specialized practitioners, and we support the proposal to ensure that patients receiving services in RHCs and FQHCs have access to these services.

Telehealth and Other Services Involving Communications Technology

The HFSA is appreciative of the efforts made by both HHS and CMS during the COVID-19 PHE to safely expand access to health care through the flexibilities and waivers implemented for furnishing medically necessary care to beneficiaries via telehealth. We believe this has been and will continue to be an important tool as we continue our work to protect the health of Medicare beneficiaries during the pandemic.

As part of this proposed rule, CMS creates a new designation for approved Medicare telehealth services, Category 3, to describe services that would be included on the Medicare telehealth services list on a temporary basis and further proposes that those codes that receive the Category 3 designation would remain on the list of proposed services for some period of time longer than the official designation of the PHE (e.g. through December 31, 2021 even if the PHE declaration was rescinded prior to that date). The HFSA supports the creation of this designation. We believe that furnishing certain medically necessary services via telehealth will be an important tool, not just during the PHE,

but also during what is expected to be a significant period of recovery. The ability of providers to rely on Medicare's telehealth policy through the end of CY 2021 will assist in providing care safely to Medicare beneficiaries regardless of whether the PHE is still in effect.

However, we are disappointed to see that CMS did not propose to add to the list of Category 3 services codes for cardiac and pulmonary rehabilitation. The HFSA urges CMS, in line with the recommendations of the ACC, to add the following codes to the list of Category 3 telehealth services:

- CPT 93797 (*Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitor (per session)*)
- CPT 93798 (*Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)*)
- HCPCS G0422 (*Intens cardiac rehab w/exerc*)
- HCPCS G0423 (*Intens cardiac rehab no exer*)
- HCPCS G0424 (*Pulmonary rehab w/ exer*)

We are concerned about programs that have suspended face-to-face programs to mitigate COVID-19 transmission risks and the negative health outcome effects this will have on patients who benefit from cardiac rehabilitation services. We believe that by allowing these services to be furnished via telemedicine where it is appropriate for the patient receiving the service that the Agency will be supporting effective care for patients that benefit from these services until face-to-face provision of these services can be safely resumed.

Thank you for your consideration of these views. If you have questions or require additional information, please contact John Barnes, HFSA Chief Executive Officer, at jbarnes@hfsa.org.

Sincerely,



Biykem Bozkurt, MD, PhD, FHFA
President
The Heart Failure Society of America