American Academy of
Allergy Asthma & Immunology

September 13, 2021

Chiquita Brooks-LaSure, JD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure,

Established in 1943, the American Academy of Allergy, Asthma & Immunology (AAAAI) is a professional organization with more than 7,000 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases. In the paragraphs that follow, we provide feedback on key proposals in the aforementioned rule, which includes input from AAAAI's Committee on the Underserved emphasizing the impact on health disparities.

Conversion Factor

CMS estimates the CY 2022 conversion factor (CF) to be $33.5848, down $1.31 from the CY 2021 CF, reflecting a mandatory budget neutrality adjustment (i.e., -0.14 percent), the 0 percent update adjustment factor specified under MACRA, and the expiration of the 3.75% increase provided under the Consolidated Appropriations Act, 2021 (CAA). Ongoing reductions to the conversion factor are not sustainable and have a significant negative impact on A/I practices, particularly those that serve vulnerable and underserved populations.

We recognize that CMS must implement the law as written, however, we are increasingly frustrated by ongoing reductions in payment. Almost every other provider type in Medicare (e.g., acute care hospitals, hospital outpatient departments, ambulatory surgery centers) receives a yearly increase in their base payment rate. Physicians, on the other hand, have not had a meaningful update despite facing the same inflation increases.

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In fact, the proposed conversion factor – if implemented on January 1, 2022 – will be lower than it was more than two decades ago. Given this Administration's prioritization of improving access to care and health outcomes for vulnerable populations, we urge you to work with Congress and other appropriate Congressional advisory bodies, on a long-term solution to these repeated cuts. Without a meaningful fix to Medicare physician payment, it will be impossible for CMS and physicians to achieve this shared goal.

Clinical Labor Pricing Update

CMS proposes to update clinical labor pricing inputs as part of the practice expense relative value unit (PE RVU) calculation, which will reduce overall payments to A/I practices by approximately 2 percent; however, a number of key A/I services face substantial decreases – despite the increased cost in providing these services as reflected by the increase in clinical labor rates.

We fully appreciate the need to update clinical labor costs to reflect the current wage market, however, the budget-neutral aspect of the PE diminishes any increased payment to offset those costs. At a minimum, CMS should phase-in these changes over a four-year transition. Consistent with the above, we urge CMS to work with the Congress to identify a long-term solution to the continued cuts in Medicare payment to physicians.

Telehealth and Virtual Care

We continue to appreciate the flexibilities provided through CMS' COVID-19 blanket waivers and interim final rules. These policies have significantly improved access to A/I care for beneficiaries during the public health emergency (PHE), particularly those who are immune-compromised and need to reduce their risk of exposure to SARS-CoV-2. Even prior to the PHE, studies have demonstrated that telehealth reduces costs, increases access and improves overall care. With that, we support CMS' proposal to retain all Category 3 services on the Medicare telehealth services list until the end of CY 2023. We also urge CMS to continue, beyond the PHE, allowing physicians to provide direct supervision through the use of real-time audio/visual technology.

In addition, while we appreciate CMS' intent in proposing to permanently implement HCPCS code G2252 (i.e., virtual check-in) and continue the direct crosswalk to CPT code 99442, we urge you to consider the recommendation from the American Medical Association (AMA) Relative Value Services Update Committee (RUC) and work with the AMA Current Procedural Terminology (CPT) Editorial Panel to revise CPT codes 99441-99443, which are used by private payers, to promote consistency in reporting this important service.

Further, we urge CMS to expand the definition of interactive telecommunications system to include audio-only communications technology when used to furnish evaluation and management (E/M) services – not just mental health services. This flexibility is critically important where broadband access limits both audio and video capabilities, and where seniors face technical and financial difficulties using or purchasing the required technology to support video visits.

Finally, we continue to urge CMS to seek the necessary authority to remove key barriers to telehealth services beyond the PHE, including statutory originating site requirements and geographic restrictions. Simply removing these two impediments would drastically improve access to telehealth services for beneficiaries. In the interim, CMS should encourage states to adopt the Interstate Medical Licensure Compact (IMLC), which currently includes 30 states, to improve access to care across state lines.

Comment Solicitation for Impact of Infectious Disease on Codes and Ratesetting

Last year, the AMA CPT Editorial Panel established CPT code 99072, *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease,* to provide financial relief for some of the direct practice expenses associated with the pandemic. The AMA and medical specialty society community urged CMS to cover and make payment for this new code, which would provide needed financial relief to physician practices when providing care to COVID-19 *and* non-COVID-19 patients in their practices. Unfortunately, CMS deemed CPT code 99072 a "bundled service," which failed to meaningfully improve payment to providers for their increased costs during these unprecedented times. We again urge CMS to make reasonable payment for the newly established code for physicians treating patients in the office amidst the ongoing COVID-19 pandemic.

MIPS Value Pathways (MVPs)

As we've shared in prior comments, we continue to have concerns with the move toward MIPS Value Pathways, which CMS intends to implement in CY 2023. Despite key aims of the new reporting pathway (e.g., streamlined reporting, increased clinical relevance), it retains aspects of the current program that clinicians find most frustrating (e.g., flawed scoring policies, limited specialty-focused measures, inappropriate cost measures). Moreover, clinicians are exhausted by the significant year-over-year changes in MIPS which add to the already burdensome nature of the program. Rather than implement another iteration of MIPS, CMS should study the impact of the current program to better understand how it has improved the quality and experience of care, reduced program and beneficiary costs, and promoted positive health outcomes in key populations, including the underserved. These findings should inform any future changes.

Qualified Clinical Data Registry (QCDR) Policies

Like many other specialty societies, AAAAI has made tremendous investments in establishing and maintaining an A/I-focused QCDR. Unfortunately, however, CMS' ongoing modifications and revised requirements have increased the time, effort and complexity associated with maintaining this valuable tool. We've shared our concerns in prior comments, for example, emphasizing the challenges with CMS' data validation requirements that are impractical and unreasonable for most specialty society QCDRs. Not only is CMS planning to codify these requirements in regulation, the agency is also proposing to require QCDRs to support various other reporting entities and pathways, including MVPs and alternative payment models (APMs), and their associated subgroups. We urge CMS to streamline and simplify its QCDRs requirements in ways that ease the administrative burden on the specialty societies who manage them.

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We appreciate the opportunity to provide comments on the aforementioned issues of importance to our members. Should you have any questions, please contact Sheila Heitzig, Director of Practice and Policy, at sheitzig@AAAAI.org or (414) 272-6071.

Sincerely,

Gurkle Mosnaim M.D.

President, American Academy of Allergy, Asthma & Immunology