



**Association of
American Medical Colleges**
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David J. Skorton, MD
President and Chief Executive Officer

March 20, 2020

Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20001

Re: Request for Additional Flexibilities During the COVID-19 National Emergency

Dear Administrator Verma:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for your continued efforts to combat the Coronavirus Disease 2019 (COVID-19) outbreak caused by the SARS-CoV-2 virus and to offer additional assistance and recommendations, which are actionable both immediately and in the long-term, as the government and the health care community continue to respond. Our member teaching hospitals and physicians have risen to the call to be on the front lines of this pandemic, and their efforts are a needed cornerstone in mitigating this crisis.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Major teaching hospitals and medical schools have mobilized on all fronts to contain and mitigate COVID-19 and, across the country, have been executing their emergency response plans and protocols, and working closely with their colleagues at state and local health departments who are stretched especially thin. Because of their expert faculty physicians, health care teams, and cutting-edge medical technology, AAMC-member teaching hospitals and physicians provide care for complex patients and often receive transferred patients for whom other hospitals cannot care. Major teaching hospitals consistently maintain a heightened level of preparedness to mobilize rapidly in response to any event at any time. This unique proficiency helped to lead the nation's response to past public health emergencies and disease outbreaks such as measles, Ebola, and H1N1, and now is a key asset in combatting COVID-19. Simply put – this is what we do.

Our teaching hospitals provide 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and are home to 69% of all Level 1 trauma centers. As major centers of medical research in addition to patient care, scientists at medical schools and teaching hospitals conduct over 50% of extramural research funded by the National Institutes of Health (NIH). This research commitment has enabled AAMC-member institutions to use their capacity to develop much-needed tests for COVID-19 and continue to provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. Our emergency rooms are open to anyone in need, with experts in every medical specialty available 24/7.

The AAMC is grateful for the president's declaration of a national emergency, which has proven to be a crucial step in this response. This declaration, through critical guidance issued by federal agencies including the Centers for Medicare & Medicaid Services (CMS), has given agencies and stakeholders targeted additional flexibility to address immediate challenges and prevent further issues, as a complement to the recent emergency declaration issued by the Department of Health and Human Services (HHS).

These steps have been critical in responding to COVID-19, and we appreciate that Congress and the Administration are working to advance additional legislative and administrative actions. The AAMC strongly supports these efforts, particularly the opportunities to mitigate the pandemic's impact on vulnerable individuals, populations, and families. Major teaching hospitals disproportionately care for underserved communities and are already on the front lines of the nation's response. As you move forward with agency actions, we urge you to equip major teaching hospitals and faculty physicians across the country with the resources and authorities they need to sustain a vigorous response.

Given that we are on the front lines, we are seeing first-hand the needs and the impact of this pandemic on the ability to both address this crisis and simultaneously maintain other critical services and activities. Our top concerns include shortages of personal protective equipment (PPE), limited testing resources, capacity of the health care workforce, strained financial resources to address developing needs for preparedness and response, research coming to a halt as we divert resources to the COVID-19 response, the impact on vulnerable populations, visa and immigration complications, and patient coverage for testing and treatment. We recognize that many of these issues are outside the scope for CMS, and we will continue to partner across other agencies across HHS and with Congress to find solutions.

It will be absolutely essential to ensure that CMS continue to support the urgent needs of the health care community without delay. Our recommendations are as follows:

Provide Flexibility Needed for Services that Involve Residents

Telehealth

The recent COVID-19 public health emergency has created significant demand for services to be furnished via telehealth. On March 17, CMS announced that it would be waiving the geographic

location requirements for a service that is normally delivered via a face-to-face interaction between the patient and the physician to be delivered via telehealth. CMS' waiver no longer requires the patient to be in a rural area for service to be delivered via telehealth. It also allows a patient to be in their home when receiving the service rather than a physician's office or a health care facility. CMS has a separate policy that when a teaching physician is involved in a service with a medical resident, the physician must be present for the critical or key portion of the service for the service to be billed under Medicare Part B. Under the primary care exception (PCE) to the teaching physician rules, a teaching physician does not have to be present for the critical or key portion of the service when a resident is performing level 1-3 E/M services and the annual wellness visit. Residents are overseen through direct and indirect supervision. Indirect supervision occurs based on the experience of the resident and the complexity of the task. The primary care exception in essence allows indirect supervision, the attending is not present but is responsible for the care of the patient and the supervision of the resident. **The AAMC asks that CMS acknowledge that the primary care exception applies to services delivered via the telehealth benefit, and also that the teaching physician does not have to be available and have no other duties when billing under the PCE but will provide indirect supervision per the PCE.** These are critical waivers that are necessary to expand coverage.

Teaching Physicians and Physical Presence

A second waiver related to residents involved in services that are billed by teaching physicians also is needed. Currently, there is a requirement for teaching physician presence during the key or critical portion of a service. The teaching physician should be able to exercise judgement to decide as to when it is appropriate for a particular resident to provide services during which the teaching physician is **not** present, but that indirect supervision occurs. The teaching physician will review the care and the resident's note at a later time and will include an attestation that he/she has reviewed the resident's care provided. The service will be billable to Medicare.

Promote Use of a Uniform Waiver for States to Waive Licensure Requirements to Allow for Telehealth Across State Lines

While we appreciate that CMS has removed Medicare provider enrollment barriers for related to state licensure, the issue remains that each state must affirmatively waive its licensure requirements to fully remove barriers to practice across state lines. We ask that CMS **immediately communicate to the states the need for every governor to waive their licensure requirements for all health care workers.** We understand that model language is being developed for use by states. As it is imperative that all state waivers be consistent to ensure that providers can move easily to where they are needed most, we further **urge CMS to promote the use of a uniform waiver.**

Assist Hospitals with Accelerated Access to Cash

Hospitals across the country are proactively postponing or cancelling non-essential "elective" surgeries, both to accommodate the expected surge of COVID-19 patients and to minimize risk of infection. At many institutions, these scheduled, non-urgent services make up a substantial

proportion of daily operations. As a result, hospitals' costs are mounting as they prepare for the pandemic, while revenue lags markedly. Hospitals that are already operating at or near negative margins will struggle to fill that gap and continue normal or heightened operations. **CMS should consider the accelerated payments in Medicare Part A, and Advance Payments in Medicare Part B, or use periodic interim payments (PIPs) to assist with cash flow at hospitals.**

Withdraw the Proposed Medicaid Fiscal Accountability Regulation

Supplemental payments are a long-standing and essential part of the Medicaid program, making up a quarter of all Medicaid payments to hospitals nationwide and being a significant source of funding for teaching hospitals as well as many physicians who practice at teaching hospitals and medical schools who provide significant care for Medicaid beneficiaries. Examples of programs at academic medical centers supported by the supplemental program include telehealth services, telepsychiatry, access to complex cancer care, and ambulatory clinics. The proposal would have a severe impact on providers who rely on those funds to care for vulnerable patients and could cause state Medicaid programs to limit or eliminate graduate medical education funding, thus endangering training programs and reducing beneficiary access. **CMS should withdraw the proposal to ensure it does not further exacerbate strain on hospitals and patient access to care during this emergency.**

PAYMENT FLOWS TO MANAGE INCREASED BURDEN ON HOSPITALS

Site-neutral Payment Cuts: As hospitals are facing extreme financial pressures, CMS should immediately cease paying claims for clinic visits provided at excepted off-campus provider-based departments at the reduced payment rate implemented with the 2020 Medicare final rule governing the hospital outpatient prospective payment system. The complexity of these visits was already high and will likely become more complex as health systems and hospitals try to keep individuals with multiple complex conditions away from the hospital. Instead such clinic visit claims should be paid at the rate that would have been in effect absent the payment reduction to ensure patients get the care they need.

SIMPLIFICATION FOR CARE DELIVERY

New Electronic Notification Requirements: Delay implementation of recently released final rule entitled "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers,"¹ adding a new Condition of Participation to require hospitals, including psychiatric and critical access hospitals, to send electronic notifications of a patient's admission,

¹ Not yet published in the Federal Register, available on CMS website here: <https://www.cms.gov/files/document/cms-9115-f.pdf> (released March 9, 2020).

discharge, and/or transfer (ADT) to another health care facility or to another community provider or practitioner, effective six months after the publication of the final rule, which is still pending.

Appropriate Use Criteria (AUC) Program: Delay implementation of payment consequences associated with the AUC program to CY 2022 to allow stakeholders use both CY 2020 and CY 2021 to learn, test, and prepare for the AUC program.

Physical Environment: Waive physical environment requirements at 482.41 to allow non-hospital buildings and spaces to be used for patient care

EMTALA Sanctions Waiver: Encourage all hospitals to be expansive in their definitions of who can provide medical screening exams under EMTALA, taking into account the licensure and training of individuals.

Physician Privileging: Waiving certain physician privileging requirements at 482.22(a) to allow physicians whose privileges will expire and new physicians to begin practice before full medical staff/governing body review and approval.

Credentialing: Require expedited or presumptive credentialing, such as requiring health plans to establish a process to recognize and credential community physicians who offer to work at hospitals and health systems to ease workforce shortages during this time.

Administrative Timeframes: Allow leniency in administrative timeframes, including to timely filing periods at 424.44 and 447.45 for Medicare and Medicaid billing and the submission of Medicare Cost Reports, for hospitals/health systems that experience business disruptions, e.g., as a result of workforce shortages.

Coordination with Other Payers: Encourage commercial health plans and managed government plans to follow the same flexibilities as Medicare in regard to access to telehealth services, cost sharing, prior authorization, etc. so that hospitals can work across consistent guidance during the emergency. Where there is authority, CMS should require plans to accept presumptive authorization in instances where health plans, due to business disruption such as reduced workforce capacity, cannot adjudicate requests within a timely manner, and to hold the patient harmless for out-of-network care and negotiate reimbursement with the provider.

Good Samaritan Protection: Support Congressional action on the Good Samaritan Health Professionals Act to provide protections for physicians and other medical professionals from medical liability exposure when they volunteer to provide medical services across state lines during a federally declared disaster, national emergency, or other public health emergency.

QUALITY REPORTING AND MAINTAINING THE TRANSITION TO VALUE-BASED CARE

Hospital Quality Reporting and Performance Programs: Suspend collecting all quality data used for the quality performance and payment programs during the emergency period. Make

appropriate adjustments to measure risk models to address impact of COVID-19 on performance to ensure providers are not penalized for circumstances beyond their control.

MIPS Reporting: Extend the upcoming March 31 MSSP and Merit-based Incentive Payment System (MIPS) reporting deadlines for 2019 data. As health professionals prioritize their staff and administrative resources toward addressing this crisis, it will be challenging to meet these regulatory deadlines.

MIPS Value Pathway Implementation: Consider delaying implementation of the MIPS Value Pathways in 2021 or committing to a gradual implementation timeline.

Alternative Payment Models and Performance: Hold clinicians harmless from performance-related penalties for the 2020 performance year, particularly those in two-sided risk models. Make appropriate adjustments to address the impact of COVID-19 on financial expenditures, performance scores, patient attribution, and risk adjustment to ensure providers are not penalized for circumstances beyond their control.

Alternative Payment Models Applications: Extend application timelines and/or provide additional application opportunities to join alternative payment models.

In addition, the AAMC supports the regulatory relief recommendations submitted by the American Hospital Association (AHA) to HHS Secretary Alex M. Azar on March 16, 2020.

The AAMC appreciates your consideration of our suggested areas for greater regulatory flexibility during this national emergency and we look forward to continued co-operation between our members and the agency during this critical time. Should you have any additional questions, please do not hesitate to contact me directly or AAMC Chief Health Care Officer Janis M. Orłowski, MD (jorłowski@aamc.org) and AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org).

Sincerely,



David J. Skorton, MD
President and Chief Executive Officer
Association of American Medical Colleges