Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

Submitted electronically via www.regulations.gov

June 1, 2020

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1744-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

***RE: Medicare and Medicaid Programs; Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency* (CMS-1744-IFC)**

Dear Administrator Verma:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or Agency's) interim final rule with comment period (IFC) entitled, "Medicare and Medicaid Programs; Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency," 85 *Fed. Reg.* 19230 (April 6, 2020). We appreciate the significant actions you and the agency have taken during the COVID-19 pandemic to support hospitals and physicians by providing regulatory relief and flexibility throughout the health care system. These changes have increased the ability of the nation's teaching hospitals and faculty physicians to expand vital care to patients.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patientcare, 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.

AAMC member teaching hospitals, because of their expert faculty physicians, health care teams, and cutting-edge medical technology, provide care for complex patients and often care for patients for who are unable to receive care elsewhere. For example, 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. Our members are well-established and respected regional referral centers and centers for tertiary care. They have years of experience in mobilizing resources during a time of crisis, and often lead regional responses in collaboration with their state and local departments of health, regional emergency management systems, and all other major players in emergency response. States and localities look to our members for launching initial responses and to aid the development of regional response networks. Their communities know that their emergency rooms are open to anyone in need, with experts in medical specialties available 24/7.

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). Many of our member institutions have developed much-needed tests for COVID-19, a fluid and rapidly changing area as they bring new equipment online, try to source materials, and stand up reporting procedures in battlefield-like conditions. Our members continue to provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research.

The COVID-19 pandemic has posed enormous challenges and has placed tremendous stress on our entire health care system – but teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19 and to freely share the knowledge that they gain with others. We are grateful that CMS has continued to be a partner with providers and the tremendous efforts made to quickly evaluate opportunities for flexibilities from current policies to ensure providers can deliver quality care for all patients during the public health emergency.

The AAMC's key recommendations on the interim final rule include the following:

- Support the telehealth waivers and flexibilities included in the interim final rules published April 6 and May 8 and urge Congress and CMS to amend legislation and regulations in the future to make these telehealth changes permanent.
- Support the expansion of the current regulations to allow teaching hospitals to claim DGME and IME for the time a resident performs patient care activities within the scope of their approved program in their own home, or in an established patient's home for the duration of the public health emergency (PHE) and ask CMS to make this change permanent.
- Support the revised rule regarding resident moonlighting during the PHE.
- Support payment for the telephone only E/M code and recommend that this payment be equivalent to payment for E/M services provided as telehealth using video and audio.
- Support the expansion of the telehealth list to include additional services and recommend these services be included permanently on the telehealth list.
- Support the inclusion of both new and established patients for telehealth services and for virtual check-in services during the PHE, recommend CMS apply flexibility to enable greater use of interprofessional consultations, and other forms of remote care delivery, during the PHE, and consider making the changes permanent.
- Support the option for teaching physicians to provide supervision via real-time, interactive audio/video technology during the PHE and consider making the changes permanent.
- Support revisions to rules for residents regarding the Primary Care Exception, teaching physician supervision for the billing of E/Ms, and supervision for the interpretation of diagnostic radiology and other diagnostic tests and psychiatric services during the PHE, and ask that CMS make the changes permanent.
- Support payment during the PHE for routine nursing and related services, use of hospital facilities, and medical social services as inpatient hospital services, even when the hospital provides the services under arrangements outside of the hospital, and ask CMS to make this change permanent.
- Recommend CMS extend the date by which ACOs can terminate participation without loss in the Medicare Shared Savings Program and extend the Next Generation ACO Model for at least one additional performance year to allow ACOs participating in that Model the ability to participate in a Medicare ACO program in 2021.

- Request CMS pay PY 2018 Advanced APM (AAPM) bonuses for qualified participants and PY 2019 shared savings as soon as possible and calculate PY 2019 AAPM bonuses on CY 2019 instead of CY 2020.

MEDICARE TELEHEALTH SERVICES

The AAMC strongly supports the waivers and regulatory changes established by CMS, which help to address the crisis caused by COVID-19 by facilitating the widespread use of telehealth and other communication-based technologies. Teaching hospitals, faculty physicians, and other providers have responded by rapidly implementing telehealth in their practices in order to provide continued access to medical care for their patients. Physicians have been able to monitor non-critically ill COVID-19 positive patients, follow up on other individuals with chronic disease who can be cared for without risking a visit to the hospital or clinic, and provide care for many Medicare beneficiaries without imposing the burden of travel. We have heard from some faculty practices that they are providing approximately 50 percent of their ambulatory visits through telehealth during the COVID-19 pandemic, a dramatic and positive increase from the use of telehealth prior to the crisis.

While the use of telehealth has been of great benefit for patients, he development of telehealth capabilities has required investing significant resources in the technology, training, and infrastructure. The flexibilities provided by CMS for telehealth coverage and payment have enabled teaching hospitals, teaching physicians, and other health care providers, and their patients to experience the benefits of telehealth. Beyond aiding with the COVID-19 response, telehealth offers the long-term promise of expanding quality healthcare in the future, particularly to individuals with limited access to services, individuals with disabilities, and elderly patients who have difficulty traveling.

We recognize that the current flexibilities described in this interim final rule are limited to the Public Health Emergency (PHE). However, it is imperative that the progress that has been made since March continue when the PHE ends. Therefore, we urge Congress and CMS to make changes to legislation and regulations that will make permanent the current changes and will ensure that reimbursement remains at a level that will support the infrastructure needed to provide telehealth services. At a minimum, we urge you to maintain these telehealth waivers and flexibilities for at least one year following the end of the PHE, to allow sufficient time for legislation to be enacted and notice and comment rulemaking to occur. Comments on the specific provisions pertaining to telehealth and communication-based technology included in the interim final rule follow.

PAYMENT FOR MEDICARE TELEHEALTH SERVICES UNDER SECTION 1834(M)

Waiver of Patient Location Restrictions

The AAMC strongly supports changes made in the interim final rule that waive patient location restrictions as previously existed. Under this change, CMS can make payment for telehealth services, including office, hospital and other visits furnished by physicians and other health care providers, provided to patients located in any geographic location and at any site, including the patient's home. This will allow patients to remain in their home, reducing their exposure to COVID-19 and reducing the risk that they expose another patient or their physician to COVID-19.

In the interim final rule, CMS states that if the telehealth visit is a service that would have been provided in the physician's office, the telehealth services would be reported with the -95 modifier and paid at the non-facility physician fee schedule (PFS) rate. CMS will pay the PFS non-facility rate as it recognizes that the cost of furnishing these services via telehealth may not significantly differ from resource costs involved when these services are furnished in person. This maintains the overall relativity in

reimbursement, particularly for services that would have been provided face-to-face, but for the public health emergency. The AAMC strongly agrees with this rationale and supports paying the same amount for telehealth services as for in-person services.

In its rationale, CMS states "we expect that physician offices will continue to employ nursing staff to engage with patients during telehealth visits or to coordinate pre- or post-visit care, regardless of whether or not the visit takes place in person, as it would have outside of the PHE for the COVID-19 pandemic, or through telehealth in the context of the PHE for the COVID-19 pandemic."

In the March 31 interim final rule, CMS states that when the physician is providing the telehealth service from a provider-based entity (such as a hospital), CMS will pay the PFS facility payment amount. We recommend CMS provide a facility fee under the OPPS for telehealth services provided by physicians that would have been provided in the provider-based entity. CMS could recognize the costs of these resources by either paying the facility or OPPS rate to the provider-based entity or reimburse the physicians at the PFS non-facility rate for the telehealth services that are being furnished in the provider-based setting**.** Similar to the physician office-based setting, the provider-based entities will continue to employ nursing, medical assistants, and other staff to engage patients during telehealth visits or to coordinate pre-or-post visit care, regardless of whether the services are furnished in person. The provider-based entity incurs these costs associated with providing the telehealth service and should be reimbursed as if the services were provided in person. We were pleased that in the second interim final rule published April 30, CMS decided to pay an originating site fee to recognize the costs incurred by hospitals.

Addition of Services to Medicare Telehealth List

The interim final rule also adds multiple services to the Medicare telehealth list, allowing payment to be made for those services. CMS also makes easier the process to request the addition of services to this list. Specifically, CMS added emergency department evaluation and management (E/M) codes 99281-85, observation and discharge day management codes 99217-20, 99224-26, 99234-36, and critical care services codes 99291-92, among others, to the telehealth services list. The AAMC supports the addition of these services to the Medicare telehealth list and recommends they be included permanently on the list.

COMMUNICATIONS TECHNOLOGY-BASED SERVICES

Virtual Check-in Codes

In the CY 2019 Medicare Physician Fee Schedule final rule, CMS finalized payment for virtual check services G2010 and G2012. These services are limited to established patients and require beneficiary consent must be obtained annually (as revised in the CY 2020 Medicare Physician Fee Schedule final rule). In the interim final rule, CMS finalizes that the virtual check-in services could be provided to both new and established patients, and also clarifies that the annual consent can be documented by auxiliary staff under general supervision. CMS states that while beneficiary consent is still necessary, they do not believe that the timing or manner in which beneficiary consent is required should interfere with the provision of the services. They finalize in the interim final rule that while the consent is required annually, it may be obtained at the same time that the service is furnished. The AAMC strongly supports the ability of providers to obtain beneficiary consent for these services at the time of service. We also support the expansion to include both new and established patients in the provision of virtual check-in services during the public health emergency.

Interprofessional Consults

As stated, we appreciate the recent steps taken to expand telehealth and the use of communication-based technology during the COVID-19 pandemic. We would urge an additional change to policies regarding interprofessional consults that would enable better access to quality care for patients during the pandemic.

During the COVID-19 pandemic, there has been an increase in physician interprofessional consultations occurring in the inpatient hospital setting, which could be billed to Medicare using the CPT Codes for Interprofessional Telephone/Internet/Electronic Health Record Consultations: 99446, 99447, 99448, 99449, 99451 and 99452. These services allow physicians to obtain interprofessional consults without exposing patients and health care providers to the risks associated with COVID-19.

Due to the complexity of COVID-19 patients and the rapid change in their condition, these consults may need to occur with greater frequency and may be needed for continued evaluation of a medical condition. We request CMS waive the frequency limits for these services, and also allow them for the same medical condition during the PHE to allow necessary interprofessional exchange of advice while minimizing exposure risks of COVID-19 to all patients. During the COVID-19 pandemic, we ask that CMS apply flexibility to enable greater use of interprofessional consultations, and other forms of remote care delivery.

TELEHEALTH MODALITIES AND COST-SHARING

During the public health emergency CMS will interpret interactive telecommunications system requirements at 42 CFR § 410.78(a)(3) to mean multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. CMS clarifies that they want to avoid the perception that the regulation might prohibit the use of a mobile computing device that could otherwise meet the interactive requirements for Medicare telehealth services during the PHE.

OCR and OIG Enforcement Discretion

The HHS Office for Civil Rights (OCR) is also exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 pandemic. The interim final rule announced that the HHS Office of the Inspector General (OIG) released a policy statement[1] notifying providers that they would not subject to administrative sanctions for reducing or waiving cost-sharing obligations for telehealth services and other associated non-face-to-face services. The AAMC appreciates the efforts of both the OCR and OIG to exercise enforcement discretion during this public health pandemic, in order to allow physicians to furnish care in a manner that is not overly burdensome on them, but also on their patients, and will encourage them to furnish services via telehealth to as many patients as is clinically appropriate.

TELEPHONE E/M SERVICES

In 2008, the AMA CPT Editorial Panel created new codes to describe E/M services furnished online or via an audio/telephone-only interaction (CPT 98966-68, 99441-43). CMS determined at that time that these services did not meet the requirements for Medicare telehealth services. In the interim final rule published March 31, CMS finalizes, on an interim basis, payment for these services at the previously valued AMA RUC levels. The AAMC strongly supports payment for the telephone only E/M code and recommends that this payment be equivalent to payment for E/M services that are included on the telehealth list. We were pleased that CMS increased the payment rates for these services in the interim final rule published on April 30, 2020 so that they are paid the same amount as established patient E/M services. This is particularly important for Medicare beneficiaries who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Initial reports suggest that lack of video services or discomfort regarding the use of video may particularly affect the elderly or those with low socioeconomic status. We believe that this needs to be seen as an equity of access issue. Many services

[1] https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

can be clinically appropriate when provided via an audio-only interaction, and that option should exist for patients.

LEVEL SELECTION OF OFFICE/OUTPATIENT E/M VISITS WHEN FURNISHED VIA MEDICARE TELEHEALTH

In the CY 2020 Medicare Physician Fee Schedule final rule, CMS finalized changes to the framework of the office/outpatient E/M codes for CY 2021. Beginning January 1, 2021, the code level can be selected based on either the level of medical decision-making (MDM) or total time spent by the reporting provider on the day of the visit (including face-to-face and non-face-to-face time). In the interim final rule, CMS is revising their policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, and removing any requirements regarding documentation of history and/or physical exam in the medical record. The AAMC supports the additional flexibility afforded by these changes, as they will continue to reduce provider documentation and reporting burden.

COUNTING OF RESIDENT TIME DURING THE PHE

The current regulations governing direct graduate medical education (DGME) and indirect medical education (IME) payments (42 CFR §§ 413.78(g), 412.105(f)(1)(ii)(E)) permit teaching hospitals to claim the time its residents train at nonprovider sites if the hospital pays the residents' salary and fringe benefits and maintains a written agreement with the nonprovider site. Additionally, a hospital can only claim the time a resident spends in patient care activities at the nonprovider site, meaning care or treatment for which the practitioner may bill. Due to the COVID-19 PHE residents have engaged in approved patient care activities in a variety of settings not contemplated by the current regulations, including both their own homes and patients' homes.

The interim final rule expands the current regulations to allow teaching hospitals to claim DGME and IME for the time a resident performs patient care activities within the scope of their approved program in their own home, or in an established patient's home for the duration of the PHE. The teaching hospital must also pay the resident's salary and fringe and comply with the regulatory requirements at 42 CFR §§ 413.78(g), 412.105(f)(1)(ii)(E) to claim the training time. The AAMC strongly supports this change to address the shift in training to ensure DGME and IME payments reflect the significant training occurring at these sites. The AAMC also supports making this change permanent, while recognizing that all training activities must comply with ACGME requirements. Training at home or in patients' homes may continue in training programs once the PHE concludes, and teaching hospitals should be able to claim resident training performed at these sites of care.

DIRECT SUPERVISION BY INTERACTIVE TELECOMMUNICATIONS TECHNOLOGY

The interim final rule clarifies that CMS believes that the use of real-time audio/video technology allows for a billing practitioner to observe the patient interacting with the in-person clinical staff through virtual means, and therefore, their ability to provide assistance and direction could be met without requiring the physician's physical presence in the location. CMS finalized that direct supervision could be provided using real-time interactive audio and video technology, for the duration of the COVID-19 public health emergency.

Under 42 CFR § 415.172, if a resident participates in a service provided in a teaching setting, payment is made only in the teaching physician is present during the key portion of the service or procedure. Aligning with the previous change in direct supervision requirements, the interim final rule makes a change that the requirement for teaching physician presence can be met through direct supervision via

interaction telecommunications technology. The AAMC supports the option for teaching physicians to provide supervision via real-time, interactive audio/video technology during the public health emergency, and as telehealth services are extended beyond the emergency. This will allow provider, both resident and teaching physician, to reduce their in-person interaction and therefore, the risks of exposure and use of limited personal protected equipment (PPE).

Provisions in § 415.174 exempt certain office/outpatient E/M services provided in primary care centers from the physical presence requirement from the key portion of the service, limited to levels 1-3 office/outpatient E/M services, allowing the teaching physician to meeting supervision requirements by being immediately available. The interim final rule allows all levels of office/outpatient E/M services to be provided under direct supervision via interactive telecommunications technology in primary care centers. The AAMC has interpreted this to mean that the immediately available supervision requirement could be met by the teaching physician being "immediately available" via real-time audio/video technology. We also support this provision.

APPLICATION OF TEACHING PHYSICIAN AND MOONLIGHTING REGULATIONS DURING THE PHE

CMS finalizes several changes that affect medical residents and teaching physicians. The AAMC agrees with CMS that direct supervision by interactive telecommunications technology that allows the teaching physician and resident to have real-time communication is appropriate during the PHE and when the PHE is over. Regardless of whether the teaching physician is physically present during a visit or is virtually present, the teaching physician remains responsible for supervision of the resident and the care of the patient. Our comments on the various proposals are below.

Moonlighting (42 CFR § 414.208(b))

The current rule is that residents cannot moonlight in the inpatient setting of the hospital at which they are training in an approved GME residency program. CMS proposes to revise the regulation during the PHE to allow payment under the Physician Fee Schedule for services provided by fully licensed residents that are not related to their approved GME program in the inpatient setting of a hospital in which they are training. In many cases, this provision would apply to residents who are in fellowship programs and thus have completed a residency program and are fully licensed. During the PHE the Accreditation Council for Graduate Medical Education (ACGME), the organization that accredits medical residency programs, has relaxed its rules regarding moonlighting. The AAMC strongly supports the revised rule proposed by CMS during the PHE. We also support CMS making this change permanent while recognizing that all approved residency programs must comply with ACGME requirements.

Primary Care Exception (PCE)

The PCE (42 CFR § 415.174) allows a teaching physician to supervise up to four residents in a primary care center and to bill for the services of those residents. The teaching physician must have no other duties while supervising and the residents are limited to providing lower and mid-level E/M services. During the PHE CMS will allow the resident to provide all levels of an office/outpatient E/M service under the direct supervision of the teaching physician by interactive telecommunications technology. The AAMC supports both changes during the PHE and asks that CMS make the changes permanent. Whether it is appropriate for a resident to provide services at levels 4 and 5 will be up to the judgment of the teaching physician who will be billing for the service and thus assumes responsibility for the care of the patient.

E/M Services

Under 42 CFR § 415.172, if a resident participates in a service in a teaching setting, payment is made only if the teaching physician is physically present during the key portion of the service or procedure. During the PHE CMS proposes to allow the direct supervision requirement to be met through the use of

interactive telecommunications technology during the key portion of the service. The AAMC supports this change during the PHE and asks that CMS make this change permanent.

Interpretation of Diagnostic Radiology and Other Diagnostic Tests (42 CFR § 415.180) Psychiatric Services (42 CFR § 415.184)

CMS requires that for psychiatric services in which a resident is involved the teaching physician can meet the supervision requirement by observation of the service by use of a one-way mirror, video equipment, or similar device. For the interpretation of diagnostic radiology and other diagnostic tests, the resident's interpretation must be reviewed by a physician other than a resident. The Agency proposes that during the PHE the direct supervision requirements for diagnostic radiology, diagnostic tests, and psychiatry services can be met by interactive telecommunications technology. The AAMC supports these changes and asks that CMS make them permanent.

INPATIENT HOSPITAL SERVICES FURNISHED UNDER ARRANGEMENTS OUTSIDE THE HOSPITAL DURING THE PHE

Under CMS's current interpretation of its regulations at 42 CFR § 409.12, hospitals are prohibited from providing routine services "under arrangements" *outside* the hospital to its inpatients.[2] The interim final rule provides payment during the PHE for routine nursing and related services, use of hospital facilities, and medical social services as inpatient hospital services, even when the hospital provides the services under arrangements outside of the hospital. The AAMC supports this change, which offers needed flexibility for hospitals to provide services in settings outside the hospital in order to compensate for capacity and equipment limitations caused by the COVID-19 PHE. We also support making this change permanent; the added flexibility would permit hospitals to leverage care settings outside the hospital as needed and quickly respond to emergent issues like the PHE.

INNOVATION CENTER MODELS

Comprehensive Care for Joint Replacement (CJR) Model

The interim final rule expands the model's current extreme and uncontrollable circumstances policy to apply to the COVID-19 pandemic, by removing the policy's current limitation to apply only to natural disasters during a declared emergency. The AAMC strongly supports this expansion of the extreme and uncontrollable circumstances policy, including the agency's clarification that the amended policy would apply to all hospitals participating in the model due to the national scope of the COVID-19 public health emergency.

Due to the disruption of the pandemic, CMS also extends the fifth model year by three months to end on March 31, 2021. Additionally, as the Agency works on finalizing a 3-year extension of the model through separate rulemaking, CMS will update the proposed model year periods accordingly based upon the extension to MY5. The AAMC asks CMS to provide more information as to its policy rationale, as it is unclear whether the 3-month extension is due to the impact of the PHE on having sufficient volume to reconcile MY5, or on the Agency's ability to issue its final rule extend the model beyond 2021. If the former, 3 months may not be sufficient considering that the public health emergency is already five months in effect.

Next Generation ACO Model

The interim final rule does not include any policy changes related to the Next Generation ACO (NGACO) Model, which will conclude December 31, 2020. The AAMC urges CMS to extend the NGACO Model

[2] 76 *Fed. Reg.* 51711 (Aug. 18, 2011).

for at least one year to allow ACOs that have invested in this model to continue without needing to adapt to a new model at this time. This is especially critical considering that CMS has issued a second interim final rule that will eliminate the opportunity for ACOs to apply to join the Medicare Shared Savings Program in 2021.[3] Without an extension of the Next Generation ACO Model, ACOs currently taking on the highest level of risk may be unable to continue that progress to value-based care seamlessly through 2021 due to the public health emergency.

MEDICARE SHARED SAVINGS PROGRAM

Revise Program's Extreme & Uncontrollable Circumstances Policy

The interim final rule includes a provision to eliminate the restriction at 42 CFR § 425.502(f) that the Shared Savings Program's extreme and uncontrollable circumstances policy applies only if the quality reporting period is not extended, effective with the quality reporting period for the 2019 Performance Year (PY 2019).[4] We appreciate the agency's acknowledgment that the previously issued 30 day extension of the PY 2019 quality reporting period alone is insufficient relief from reporting burden for accountable care organizations (ACOs) and their providers during this public health emergency. The AAMC supports this revision.

Extend Deadline for ACOs to Voluntarily Terminate Participation Without Financial Risk

CMS did not change its current policy requiring ACOs to terminate participation effective on or before June 30 in order to leave the Program without financial risk for shared losses. This policy also requires ACOs to provide CMS 30 days' notice of termination, effectively making the timing of an ACO's termination decision no later than June 1. Due to the uncertainty of the COVID-19 pandemic, the ongoing PHE, and the Agency's subsequent issuance of its second interim final rule on May 8, the AAMC urges CMS to extend the date by why ACOs can terminate participation without loss. At a minimum, we suggest CMS extend the termination deadline to on or before August 6, 2020 (90 days from the publication of the second interim final rule) so that ACOs can better assess their local and regional pandemic situations and the policies modified by the interim final rules.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) UPDATES

Accelerate the Advanced Alternative Payment Model (AAPM) Bonus Payments

CMS should ensure that qualified participants (QPs) in Advanced Alternative Payment Models (AAPMs) receive their AAPM bonus payments as soon as possible in 2020 to help support these providers' commitment to value-based care and to help them manage reduced revenue from utilization disruptions caused by the pandemic. The payments are based upon CY 2019 claims, and CMS has the data necessary to calculate the bonus payment sums and process payment as soon as possible.

Calculate AAPM Bonus Payments for 2019 Performance on CY 2019 Claims

The agency's current policy bases a QP's bonus payment on claims from the calendar year following the performance year in which the clinician qualified for the AAPM bonus. For example, if a clinician qualifies for the AAPM bonus based on performance in 2018, the clinician will receive the 5% AAPM bonus in CY 2020, based upon CY 2019 claims data. This means that if a clinician is a QP in an AAPM in 2019, the AAPM bonus will be calculated using CY 2020 claims data. CMS should amend the policy

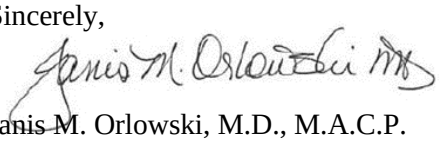
[3] "Medicare and Medicaid Programs, Basic Health program, and Exchanges: Additional Policy and Regulator Revisions in Response to the COVID-10 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," CMS, 85 *Fed. Reg*. 27550 (May 8, 2020) at 27574
[4] *See* 85 *Fed. Reg*. at 19268

for PHE due to the utilization disruptions in CY 2020, and instead use CY 2019 claims data to calculate the AAPM bonus. This had an added bonus that by doing so, CMS could issue 2019 bonus payments immediately in CY 2021 and help with cash flow issues that are likely to linger beyond 2020.

CONCLUSION

We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact me or Ivy Baer at ibaer@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer, AAMC

cc: Ivy Baer, J.D., M.P.H, AAMC