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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, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program (CMS-5531-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, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-10 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," 85 *Fed. Reg.* 27550 (May 8, 2020). We support and recognize 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 and we greatly appreciate CMS's partnership during this Public Health Emergency (PHE).

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 who are unable to receive care elsewhere. For example, our member teaching hospitals represent 5% of all hospitals, yet 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 and receive 40% of all transfer cases nationwide. 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.

While the COVID-19 pandemic has posed enormous challenges and has placed tremendous stress on our entire health care system, teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to treat 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 appreciate 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 PHE.

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

- Reiterate support for the telehealth waivers and flexibilities including in the interim final rules published April 6 and May 8 and urge CMS and Congress to amend regulations and legislation in the future to make these changes to telehealth policies permanent.
- Support the exclusion of increased inpatient beds from the calculations to determine indirect medical education (IME) payments and urge CMS to make this a permanent policy whenever there is a PHE declaration.
- Support the expansion of services under the Primary Care Exception under the Teaching Physician Regulations.
- Support the inclusion of time spent by residents at another hospital for the purposes of direct graduate medical education (DGME) and IME payments and urge CMS to continue this policy after the PHE.
- Support the temporary expansion locations of a hospital to include the patient's home, but request CMS eliminate the requirement to submit addresses of temporary locations to the CMS Regional Office due to significant burden.
- Support the inclusion of FDA-authorized COVID-19 serology tests for Medicare coverage and urge CMS to continue coverage when the PHE ends.
- Support the delayed implementation of Merit-Based Incentive Payment System (MIPS) qualified clinical data registry (QCDR) measurement.
- Support the consistent approach to Extraordinary Circumstance Exception (ECE) policies across hospital quality reporting and performance programs and urge CMS to suspend the hospital quality performance programs during the PHE.

- Support adjustments to the Medicare Shared Savings Program calculations to address the unanticipated increase in expenditures due to the PHE and urge CMS to address the impact of 2020 calendar year expenditures on 2021 risk adjustment in the program.

MEDICAL EDUCATION

Holding Hospitals Harmless from Reductions in IME Payments Due to Increases in Bed Counts Due to COVID-19

Many teaching hospitals have increased the number of inpatient beds to accommodate patients diagnosed with coronavirus that require inpatient care. We voiced concerns to CMS that the increase in inpatient beds would unfairly negatively impact the intern and resident-to-bed ratio used in the calculation of IME payments. In the IFC, CMS agrees with these concerns noting that the increase in inpatient beds due to the PHE should not negatively impact IME payments. For the purposes of determining a hospital's IME payment amount for the duration of the PHE, "the hospital's available bed count is considered to be the same as it was the day before" the PHE was declared. "Beds that were temporarily added during the PHE are excluded from the calculations to determine IME payments."¹ We appreciate CMS's acknowledgement that an increase in beds is a necessary part of hospitals' response to the PHE and strongly support the policy. We ask that CMS make this policy permanent to apply whenever there is a declaration of a PHE.

Time Spent by Medical Residents at Another Hospital During the COVID-19 PHE

Under current Medicare rules, hospitals cannot claim the time medical residents spend training in other hospitals for the purposes of DGME payments or the IME adjustment. CMS recognized that in response to the PHE, teaching hospitals need increased flexibility to assist with caring for patients by allowing residents to be sent to other hospitals, including some that may be non-teaching hospitals. CMS is allowing teaching hospitals "to claim for purposes of DGME and IME payments the time spent by residents training at other hospitals during the PHE,"² provided that the hospital claiming the resident pays the resident's salary and benefits. Additionally, "the presence of residents in a non-teaching hospital will not trigger establishment of per resident amounts or full-time equivalent (FTE) resident caps at those non-teaching hospitals."³ The AAMC strongly supports this policy. We request that CMS continue this policy after the PHE to allow for increased opportunities for residents to train in different settings without triggering a non-teaching hospital's Per Resident Amount (PRA) or cap. Further, we ask that CMS propose a regulatory change that would allow hospitals that have inadvertently triggered a PRA and an FTE cap in the past to be able to become teaching hospitals and establish a new PRA and build a new cap. This would provide important relief at a time when physician shortages are projected.

¹"Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-10 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," 85 *Fed. Reg.* 27550, at 27567 (May 8, 2020).

² *Ibid.* at 27568.

³ *Ibid.*

ADDITIONAL FLEXIBILITY UNDER THE TEACHING PHYSICIAN REGULATIONS

CMS adds several flexibilities to the Teaching Physician Regulations in the IFC, in addition to those in the previous IFC. In response to stakeholder requests, CMS expands the Primary Care Exception (PCE), 42 CFR 415.174. During the PHE, CMS will allow payment to the teaching physician for the following additional services when furnished by a resident under the PCE: CPT 99441, CPT 99442, CPT 99443, CPT 99495, CPT 99496, CPT 99421, CPT 99422, CPT 99423, CPT 99452, HCPCS G2012 and HCPCS G2010. The Agency also clarifies that the office/outpatient E/M level selection for services under the PCE when furnished by telehealth can be based on medical decision making or time. The AAMC agrees with the agency that for these services, including those provided via telehealth, “the teaching physician can provide the necessary direction, management and review for the resident’s services using audio/video real-time communications technology.”⁴ **The AAMC strongly supports these added flexibilities.**

TREATMENT OF CERTAIN RELOCATING PROVIDER-BASED DEPARTMENTS DURING THE COVID-19 PHE

During the PHE, CMS has relaxed the extraordinary circumstances policy to allow existing excepted on-campus and off-campus provider-based department (PBDs) to obtain a temporary relocation exception and continue to be paid the full rate under the Outpatient Perspective Payment System (OPPS). Ordinarily, an excepted PBD that relocates would lose its excepted status and instead be paid 40 percent of the OPPS payment rate for items and services furnished in the PBD. **The AAMC strongly supports this policy change and asks that CMS expand the extraordinary circumstances policy after the PHE. Excepted PBDs forced to relocate due to unforeseen circumstances beyond their control should be allowed to relocate without losing their excepted status.**

FURNISHING HOSPITAL OUTPATIENT SERVICES IN TEMPORARY EXPANSION LOCATIONS OF A HOSPITAL OR A COMMUNITY MENTAL HEALTH CENTER (INCLUDING THE PATIENT’S HOME)

CMS waives certain Medicare conditions of participation to facilitate the availability of temporary expansion locations. This allows temporary expansion locations, including beneficiaries’ homes, to become PBDs of a hospital and bill for services furnished under the OPPS during the PHE. The AAMC supports the flexibility provided by CMS to allow practitioners to continue to treat the health care needs of beneficiaries in the safest way possible. As part of the temporary expansion site requirements, hospitals are required to submit the addresses of temporarily relocated PBDs to the CMS Regional Office. We have heard from members that this requirement is burdensome and shifts scarce resources away from managing other aspects of the PHE, including ensuring that beneficiaries continue to have access to care. The AAMC requests that CMS eliminate this requirement.

MEDICARE TELEHEALTH SERVICES

The AAMC strongly supports the waivers and regulatory changes established by Congress and CMS in the two interim final rules, 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

⁴ Ibid. at 27589.

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. A survey of faculty practice plans showed that on average, 50% of ambulatory visits were furnished via telehealth and for some practices as many as 80% were furnished via 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, the 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 PHE and we strongly support them. 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. In addition, we know that COVID-19 will remain active in our communities at a low level for several years, extending this policy for at least a year will allow the physicians the flexibility of making individual decisions on their chronically ill patients as to when an in-person visit is necessary. Comments on the specific provisions pertaining to telehealth and communication-based technology included in the interim final rule follow.

HOSPITAL SERVICES ACCOMPANYING A PROFESSIONAL SERVICE FURNISHED VIA TELEHEALTH

In the first IFC, published April 6th, CMS instructed physicians and other health care providers furnishing telehealth services to beneficiaries in their homes, as allowed under the PHE, to bill for those services as if they had been provided in person. CMS stated that when a practitioner who ordinarily practices in a hospital outpatient department (HOPD) furnishes a telehealth service to a patient who is located in their home, they would submit a professional claim and be paid at the facility rate (as if the service had been provided in the HOPD). That rule did not provide guidance for hospitals to submit a claim for the service (the originating site fee) in this scenario. The AAMC, along with other stakeholder groups, commented to CMS that a hospital should be permitted to bill a fee in addition to the physician's professional fee, as the hospital provides administrative and clinical support (e.g. nursing, medical assistants, and other staff) for these telehealth services. We were very pleased that this subsequent IFC allows that when a registered outpatient of the hospital is receiving services via telehealth, the hospital is permitted to submit a claim for the originating site fee to support the telehealth services furnished by the physician or other health care provider who normally practices there. **The AAMC strongly supports this change.**

PAYMENT FOR AUDIO-ONLY TELEPHONE EVALUATION AND MANAGEMENT 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 April IFC, CMS finalized, 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.**

The AAMC also strongly supports the increased payment rates for these services in this interim final rule so that they are paid the same amount as established patient E/M services, and we appreciate CMS taking stakeholder feedback on this issue into account. This is particularly important for Medicare beneficiaries who may not have access to, may not feel comfortable with, may not be physically or mentally able to use 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, thereby resulting in disparities in access. A patient's physician can determine when it is clinically appropriate to provide services via an audio-only interaction. CMS should continue to allow the use of audio-only technology as appropriate and should set payment rates for these services that account for the physician work and resources involved in providing these services.

TIME USED FOR LEVEL SELECTION FOR OFFICE/OUTPATIENT EVALUATION AND MANAGEMENT SERVICES FURNISHED VIA MEDICARE TELEHEALTH

In the April IFC, CMS revised its policy for the duration of the pandemic to specify that the level selection for office/outpatient E/M services when furnished via telehealth can be based on medical decision-making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS states in this subsequent IFC that the typical time for purposes of level selection are based on the times listed in the CPT descriptor. **We appreciate the reduction in burden associated with documentation of these E/M services during the pandemic and the clarification regarding how time is determined and support this change.**

UPDATING THE MEDICARE TELEHEALTH LIST

The first IFC published April 6th added multiple services to the Medicare telehealth list, allowing payment to be made for those services. CMS also simplified the process to request the addition of services to the 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 supported the addition of these services to the Medicare telehealth list and recommends they be included permanently on the list. CMS further clarified that services could be added to the Medicare telehealth list on a subregulatory basis by posting those services to the CMS website. **The AAMC appreciates this clarification, and strongly supports the ability of CMS to simplify the process to add services to the telehealth list, particularly during the PHE, when services need to be added to the Medicare list simply and swiftly, in order to have the greatest positive effect.**

PAYMENT FOR COVID–19 SPECIMEN COLLECTION TO PHYSICIANS, NONPHYSICIAN PRACTITIONERS AND HOSPITALS

Recognizing the critical importance of expanding COVID-19 testing, in this IFC, CMS provides additional payment for assessment and COVID-19 specimen collection to support testing by HOPDs, and physicians and other practitioners. The majority of ambulatory care in any community is furnished by physicians and other practitioners in offices and HOPDS, and therefore testing occurs at these locations in addition to laboratories. CMS states that for the duration of the pandemic, it will recognize physician and non-physician providers (NPP) use of CPT code 99211 for all patients, not just patients with whom they have an established relationship, to bill for a COVID-19 symptom and exposure assessment and specimen collection provide by clinical staff incident to their services. We support this policy change, which will enable expanded access to COVID-19 testing and provide appropriate payment for COVID-19 testing related services. In this IFC, CMS also creates a new E/M code solely to support COVID-19 testing (C9803) done by clinical staff from HOPDs. The OPDS will only make separate payment to a hospital when HCPCS code C9803 is billed for specimen collection without another primary covered hospital outpatient service. **We support this code as it will expand access to testing and help to reimburse for the resources used by hospitals to conduct this testing in the community.**

PAYMENT FOR REMOTE PHYSIOLOGIC MONITORING (RPM) SERVICES FURNISHED DURING THE COVID–19 PUBLIC HEALTH EMERGENCY

In the April IFC, CMS changed several policies related to payment for RPM services under the physician fee schedule to support the goal of reducing exposure to the coronavirus while increasing access to care. In this subsequent IFC CMS establishes a policy to allow remote patient physiologic monitoring services to be reported to Medicare for periods of time that are fewer than 16 of 30 days, but no less than 2 days as long as other requirements for billing the code are met. This policy would apply only to patients who have a suspected or confirmed diagnosis of COVID-19. **We support this policy as it will increase access to care and improve patient outcomes.** While it is possible that remote physiologic monitoring would be used to monitor a patient with COVID-19 for 16 or more days, many patients with COVID-19 who need monitoring require fewer days of monitoring. Providers are only just beginning to understand the “post-COVID” care needs for patients, and the AAMC may provide further recommendations in regard to RPM services as we better understand the lasting medical complications and effects of COVID-19.

OPIOID TREATMENT PROGRAMS (OTPs)— FURNISHING PERIODIC ASSESSMENTS VIA COMMUNICATION TECHNOLOGY

CMS expands telehealth flexibilities to the new G-codes established for patient assessments under OTPs to allow OTPs to provide these assessments with audio-only technology where real-time audio/video technology is unavailable. **The AAMC supports this change to ensure patients have access to these critical opioid-use disorder services from OTPs during the PHE.**

COVID-19 SEROLOGY TESTING

CMS is finalizing that “FDA-authorized COVID-19 serology tests fall under the Medicare benefit category of diagnostic laboratory test” without undergoing the National coverage decision process due to the PHE.⁵ These tests would be payable under Medicare for beneficiaries with known current

⁵ Ibid at 27598.

or prior COVID-19 infection or suspected current or past infection. CMS expects to be billed once per same and would not expect tests to be performed and billed unless clinically indicated. **We support this decision and request that CMS continue coverage when the PHE ends.**

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) QUALIFIED CLINICAL DATA REGISTRY (QCDR) MEASURE APPROVAL CRITERIA

In this interim final rule, CMS delays the implementation for two policies relating to third-party intermediary QCDR measurement in response to the PHE. First, CMS is delaying the completion of QCDR measure testing, which would have required all QCDR measures to be fully developed and tested, with complete clinician-level testing results, prior to submitting the QCDR measure at the time of self-nomination. Second, CMS is delaying the start of required data collection. In both cases, the policies impacted will be revised to state the delay and that such policies will now begin with the 2022 performance period instead of the 2021 performance period. We appreciate the Agency's recognition that QCDRs are supported primarily by hospitals directly impacted by the pandemic or by specialty societies representing and supporting clinicians on the front line of the pandemic. **The AAMC supports this policy delay in an effort to reduce burden on clinicians and hospitals that are responding to the pandemic and unable to commit resources to data collection and submission on QCDR measures in the near term.**

UPDATE TO THE HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM EXTRAORDINARY CIRCUMSTANCE EXCEPTION (ECE) POLICY

CMS finalizes changes to the VBP Program's ECE Policy codified at 42 CFR § 412.165(c) to allow the Agency to make a determination to grant an exception to *all* hospitals in a region/locale impacted by a PHE (rather than solely individual hospital exception determinations). This change aligns the VBP Program's ECE policy with the ECE policies under the Inpatient and Outpatient Quality Reporting Programs and the Hospital Readmissions Reduction and Hospital-Acquired Condition Reduction Programs (HACRP). **The AAMC supports this change and appreciates the move toward consistency of ECE policies across hospital reporting and performance programs.**

The interim final rule references the ECE guidance it issued on March 22nd and March 27th⁶ to briefly summarize the broad reporting relief through Q2 of the 2020 reporting period (covering 2020 reporting through June 30, 2020). Related to the ECE policies reference in this IFC and these guidance documents, our members have reached out to ask how CMS will apply the ECE where a hospital is located in a state that is continuing to mandate National Healthcare Safety Network (NHSN) healthcare-acquired infection (HAI) measure data during the pandemic. In those cases, there is concern that hospitals are unable to voluntarily withhold reporting as allowed by CMS, and that their performance on these measures will be scored under the VBP and HACRP and that there will be bias in the scoring if hospitals in other states do not report on these measures during the impacted reporting periods. CMS should issue additional clarification to its policy to advise whether it will apply the ECE in these cases to ensure fairness in performance programs and public reporting.

⁶ See <https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting> and <https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>

Finally, on July 2 CMS emailed an announcement⁷ that it would not extend reporting relief and flexibilities beyond June 30, 2020 and that all data collection and reporting requirements would be in effect beginning on July 1, 2020. Instead, CMS retains the normal ECE policies where hospitals may submit individual ECE requests if they are unable to meet these requirements under the normal ECE submission guidelines. **The AAMC is disappointed by the abrupt end to hospital quality reporting relief and urges CMS to consider the impacts of the continuing COVID-19 PHE on hospital performance in 2020 and suspend the hospital quality performance programs during this public health crisis.** The end of reporting relief and flexibilities is incongruous with the worsening of the crisis as we enter the third quarter of 2020.

MEDICARE SHARED SAVINGS PROGRAM

2021 Application Cycle and Extension of Agreement Periods Expiring on December 31, 2020

CMS announces that it is foregoing a 2021 application cycle for accountable care organizations (ACOs) to join or renew participation in the Shared Savings Program. This is an effort to both reduce operational burden and to avoid the use of CY 2020 as the third (and highest weighted) benchmark year for ACOs. Because there are ACOs with current participation agreements expiring December 31, 2020, CMS will provide such impacted ACOs the opportunity to extend their current agreements through 2021. **The AAMC is supportive of CMS' recognition of operational burden and added flexibility for participation and of the Agency's acknowledgement that it needs additional time to consider the role of 2020 as a benchmark year and potential policies to mitigate what will likely be an anomalous impact.** The AAMC asks CMS to be clear and transparent about any policy changes the Agency is considering for benchmarking and benchmark adjustment calculations to address the impact of 2020. This includes considerations for adjusting 2021 spending projections to account for care deferred from 2020.

Adjustments to Program Calculations to Address the Pandemic

The Agency will now remove payment amounts for episodes of care for treatment of COVID-19 from MSSP expenditure and revenue calculations for the duration of the PHE. This policy is intended to address the unanticipated increase in expenditures due to the pandemic and the localized nature of outbreaks and increased utilization and associated higher costs that would not be reflected in ACOs' historical benchmarks that would not be meaningfully adjusted by the current methodology (namely the update factor and risk adjustment). **The AAMC supports this policy change to ensure more equitable cost comparisons.** We ask CMS to consider extending this policy for the entirety of 2020, in the event the PHE is not extended beyond July 25, 2020, in order to provide more certainty to ACOs in the event of a second wave of infections and a non-continuous PHE scenario.

Additionally, CMS notes that prospective CMS-HCC risk scores central to risk adjustment to the benchmark use the prior year's diagnoses to predict costs in the current year. **The AAMC asks CMS to address the impact of 2020 on 2021 risk scores and consider policy changes to ensure that 2020 does not negatively and unfairly impact risk adjustment for the 2021 performance period.**

⁷ "CMS Announces Updates on Hospital Quality Reporting and Value-based Payment Programs due to the COVID-19 Public Health Emergency," via CMS QualityNet ListServe (July 2, 2020).

Expansion of Codes Used in Beneficiary Assignment

CMS acknowledges the expansion of Medicare payment for telehealth services in response to the COVID-19 pandemic, including new flexibilities and separate payment for certain services not considered Medicare telehealth services (such as virtual check-ins, e-visits, and telephone E/M services). As a consequence, CMS is expanding the definition of primary care services for the purposes of the Program's assignment methodology effective for the 2020 performance year and any other performance year that starts during the PHE. CMS also clarifies that as the definition of primary services did not preclude telehealth services, the majority of the codes if furnished as Medicare telehealth services, were already included in the definition of primary care services for purposes of beneficiary assignment. **The AAMC supports this change and appreciates the Agency's recognition of the increased delivery of care through telehealth due to the pandemic and clarification of the inclusion of defined primary care services furnished in accordance with the telehealth rules.** The Agency should consider whether these changes to the assignment methodology should be made permanent in the event of the expansion of telehealth policies continues beyond the duration of the PHE.

The AAMC also asks CMS to provide clarity on the provision of and billing for annual wellness visits Annual Wellness Visits (AWVs), G0438 and G0439. AWVs have been telehealth-eligible services prior to the PHE, but we have heard that there might be questions regarding when a patient is receiving the AWV service from his or her home under the expansion of telehealth originating site rules during the PHE. The AWV is a significant patient care coordination and satisfaction tool for ACOs, and there is concern that Medicare Administrative Contractors are inconsistently allowing clinicians to bill for AWVs furnished via telehealth when a patient is at home.

CONCLUSION

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. 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 Gayle Lee, galee@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
Gayle Lee, J.D., AAMC