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Via electronic submission (www.regulations.gov)

October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Attention: CMS-1734-P

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

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) 2021 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule published August 17, 2020 (85 Fed. Reg. 50074) The AAMC is a not-for-profit association dedicated to transforming health care through medical education, patient care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Through their mission of providing the highest quality patient care teaching physicians who work at academic medical centers (AMCs) provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans" because many of these physicians supervise medical residents and students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Often care is multidisciplinary and team-based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 128 individual national provider identifiers (NPI)s to a high of 4,319 NPIs, with a mean of 989 and a median of 816. These practices support the educational development of residents and physicians who will become tomorrow's physicians. Teaching physicians also provide significant primary care services to patients in their local communities.

In addition to primary care, teaching physicians provide critical other services for their local communities, including a large percentage of tertiary, quaternary, and specialty referral care. Also, teaching physicians may have a patient base that spans regions, states and even the nation. They also treat a disproportionate share of patients for whom social determinants of health, such as housing, nutrition, and transportation, contribute significantly to additional health challenges, adding greater complexity to their care. The COVID-19 pandemic has posed enormous challenges and placed tremendous stress on our entire health care system – and teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19. We thank CMS for immediately acting to reduce regulatory burden and provide flexibility during the national pandemic. We believe that many of these changes can provide greater access and improved care if they are continued in the future.

The AAMC commends CMS for its efforts to reduce burden, recognize clinicians for the time they spend with patients, allow flexibilities and waivers during the COVID-19 pandemic, and make the path toward value-based care easier. We are committed to working with CMS to ensure that Medicare payment policies ensure access to high quality care for patients, accurately reflect the resources involved in treating patients, are not overly burdensome to clinicians, and reduce health disparities.

The AAMC's key recommendations on the 2021 proposed rule include the following:

PHYSICIAN FEE SCHEDULE

- ***Budget Neutrality:*** The AAMC encourages CMS to support stakeholders' efforts to urge Congress to waive the budget neutrality requirements associated with the evaluation and management (E/M) code changes. If Congress does not act on budget neutrality before January 1, 2021, we strongly urge HHS to use the public health emergency declaration as a basis to waive budget neutrality requirements for the new office visit payments and take any other steps to stop these significant cuts. If budget neutrality is not waived, we suggest CMS consider implementing a gradual phase-in of the budget neutrality adjustment for the E/M codes over several years.

- ***E/M Coding Changes and relative value units (RVUs):*** The AAMC strongly supports CMS' proposal to adopt the coding changes and relative value units for E/M services recommended by the RUC.
- ***E/M Visit Level Selection and Documentation:*** The AAMC supports finalizing the policy for 2021 that would allow physicians to select a level and document based on either medical decision-making or time.
- ***Add-On Code (GPCIX):*** The AAMC recommends that CMS postpone implementation of the add-on code (GPCIX) until there is further clarification on how it would be used and what the impact would be on payment and redistributions among specialties. If CMS implements this add on code in 2021, we urge CMS to reconsider its utilization assumptions which account for a significant portion of the decrease in the conversion factor**.** If CMS finalizes the GPCIX code for 2021, we recommend it not apply budget neutrality to that code.
- ***Telehealth*****:** The AAMC urges Congress and CMS to make changes to legislation and regulations that will allow the current changes to telehealth, including the removal of geographic and site of service restrictions, to be made permanent while ensuring that reimbursement remains at a level that will support the infrastructure needed to continue provide telehealth services.
- ***Expansion of Telehealth Services*****:** The AAMC recommends that CMS allow all the services added to the telehealth services list during the PHE to continue to remain on the telehealth list post-pandemic to allow further study of the benefits.
- ***Category 3 Telehealth Services:*** The AAMC encourages CMS to make Category 3 permanent as an option to temporarily allow services to be billable for a defined period, while providers collect data and perform analysis on the clinical benefit of the telehealth services.
- ***Audio-Only Telephone E/M Services:*** The AAMC recommends payment for audio/only telephone E/M services be allowed beyond the end of the PHE for patients who need telecommunications-based services in the home but do not have access to video connection or cannot successfully use one.
- ***Virtual Supervision of Residents:*** The AAMC recommends CMS permanently adopt the policies in place during the PHE that allow the teaching physician presence during the provision of services by a resident to be met using real-time audio/video communications technology.
- ***Residents Providing Telehealth***: The AAMC recommends CMS allow residents to provide telehealth services permanently while a teaching physician is present via real-time audio/video communications technology after the PHE ends.
- ***Resident Moonlighting:*** Provided that moonlighting is consistent with accreditation requirements by ACGME, the AAMC supports permanently allowing residents to moonlight in the inpatient setting if the services are not related to their GME program.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

- ***MSSP Quality Changes:*** The AAMC encourages CMS to postpone for at least one year any changes to the current quality scoring program.

- ***Web Interface for ACOs*:** To give ACOs more time to prepare, the AAMC urges CMS to provide a more gradual transition away from the use of the Web Interface reporting option. At a minimum, the Web Interface must be continued as a reporting option until at least 2022.
- ***Quality Measure set for ACOs:*** While we appreciate the significant reduction in measures, the AAMC recommends CMS seek stakeholder input from the Measures Application Partnership and others prior to implementing the new measure set for ACOs.

QUALITY PAYMENT PROGRAM

- ***MIPS Value Pathways (MVPs):*** The AAMC strongly supports CMS' proposal to delay implementation of the MVPs. The MVPs should be gradually implemented to ensure that they are meaningful for clinicians and their patients, and not burdensome to report.
- ***MVPs and Large Multi-Specialty Practices:*** With the large number of distinct specialties reporting under one TIN in academic medical centers, the AAMC believes it would be very challenging to identify MVPs that would be meaningful for all specialties in the practice. A better solution would be to have subgroup identifiers that allow measurement of the performance at the subgroup level.
- ***Elimination of MIPS Scoring Standard:*** The AAMC recommends CMS maintain the MIPS APM scoring Standard and not require a transition to the APM performance pathway (APP).
- ***Removal of Web Interface:*** The AAMC strongly urges CMS to provide a gradual transition away from the use of the Web Interface reporting option. More time and thought must be given regarding how this will be implemented, and for group practices to assess their alternatives. At a minimum, the Web Interface must be continued for at least one additional year to give sufficient time for affected practices to implement a new reporting method.
- ***Cost Category:*** Given the multiple concerns under the cost performance category, including the impact of COVID-19 on patterns of care, clinicians' lack of familiarity with cost measures, the need for risk adjustment, and the need for better attribution methodologies, the AAMC strongly urges CMS to maintain the weight of the cost category at 15%.
- ***Risk Adjustment***: As appropriate, the AAMC recommends CMS risk-adjust outcome measures, population-based measures, and cost measures for clinical complexity and sociodemographic factors.
- ***Advanced Alternative Payment Models:*** The AAMC recommends CMS support any Congressional efforts that would give the Agency the discretion to set the thresholds to be qualified participants in an advanced APM at an appropriate level to encourage AAPM participation.

MEDICARE PHYSICIAN FEE SCHEDULE

The CY 2021 Medicare Physician Fee Schedule (PFS) rule proposes several policy changes which will specifically impact the teaching physicians and providers at AMCs, as well as those who provide patient care elsewhere Among the areas addressed by this letter are the significant changes to E/M coding, documentation, and payment, the expansion of telehealth and

communication technology-based services, virtual supervision, and other waivers and flexibilities established during the COVID-19 pandemic that should be made permanent.

UPDATE TO THE PHYSICIAN FEE SCHEDULE CONVERSION FACTOR FOR 2021

In the proposed rule, CMS sets forth the dollar conversion factor that would be used to update the payment rates. For 2021, the conversion factor would be $32.2605, which is a 10.61% reduction from the 2020 conversion factor.

The drastic 10.6% reduction in the Medicare conversion factor is due to the proposed additional spending in the rule of $10.2 billion. Generally, spending under the fee schedule must be budget neutral meaning that increases in spending must be offset by decreases. The changes to the E/M codes account for about half of this additional spending, and therefore, half of the reduction. The remaining spending increases and resulting conversion factor reduction is attributed to various other CMS proposals in the rule, including a proposal for an add on code for primary care and complex patients, and an increase in the values of some other codes that describe services that include or rely upon office/outpatient E/M visits.

We appreciate CMS' commitment to restructuring and revaluing office-based E/M codes and the corresponding increases in payments for primary care services. However, we are deeply concerned about the significant cuts that many clinicians will experience from adherence to budget neutrality adjustments. These cuts will be sizable for many physicians, especially those who do not report outpatient office visits frequently, such as emergency physicians, critical care physicians, hospitalists, radiologists, pathologists, and others. The cuts will also reduce the positive impact of the office visit changes for primary care physicians, oncologists, pediatricians, and others for whom office visits are a high proportion of services.

We encourage CMS to support stakeholder's efforts to urge Congress to waive the budget neutrality requirements associated with the E/M code changes. If Congress does not take action on budget neutrality before January 1, 2021, we strongly urge HHS to use the public health emergency declaration as a basis to ensure access to care and mitigate financial impacts due to the COVID-19 pandemic by implementing the office increases while waiving budget neutrality requirements for the new office visit payments. While CMS does not have explicit authority to waive the budget neutrality requirements for the PFS under section 1135 of the Act, CMS has waived other provisions of statute or regulations not specifically waivable under section 1135 of the Act using the PHE as its justification. For instance, CMS has waived the provider-based rules in their entirety without an explicit waiver authority.

Payment reductions of this magnitude would be a major problem at any time, but to impose these large cuts at a time when teaching physicians and other health care professionals continue to be on the front lines treating patients with COVID-19 will be devastating. The COVID-19 pandemic has caused significant disruption to physician practices due to cancellation of elective procedures and nonurgent patient care visits. Faculty practices 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.

Faculty practices have estimated that they have lost between 25% and 50% of their revenue in April and May 2020 as compared to 2019. While the telehealth waivers and flexibilities granted by CMS were beneficial to physicians and their patients, telehealth made up a small portion of this lost revenue. In addition, practices benefited from the stimulus CARES funds but these much appreciated dollars have not filled the gap from losses. Even as operations are able to resume, it will be impossible for these practices to make up this lost revenue.

The process of ramping up operations comes with unique costs as practices need to purchase additional personal protective equipment (PPE), increase testing for staff and patients, enhance cleaning protocols, and undertake other costly measures – all while seeing a lighter patient volume to maintain adequate social distancing. Practices also need to be ready for a second surge during the winter from the combined impact of COVID-19 and the seasonal flu.

We are concerned that the additional reductions in revenue from the budget neutrality adjustments will result in further losses that will initiate further contractions in expenses and significant access problems for patients. Given these unprecedented challenges and the critical importance of patient access to health care services, we urge CMS to use flexibilities it has exercised during the public health emergency to waive the physician fee schedule budget neutrality for the E/M changes in 2021.

EVALUATION AND MANAGEMENT DOCUMENTATION AND PAYMENT CHANGES

In the proposed rule, CMS proposes to finalize significant modifications to several policies related to E/M office visits. Specifically, CMS proposes to align its E/M office visit coding changes with the framework adopted by the CPT Editorial Panel for office/outpatient E/M visits. These coding changes would retain the five levels of coding for established patients, reduce the number of levels to four for office/outpatient E/M visits for new patients, and revise the code definitions. In addition, the times and medical decision-making process for all the codes would be revised. History and exam would no longer be used as elements for code selection; however, a history and exam would be required if medically necessary. The changes would allow clinicians to choose the E/M visit level based on either medical decision-making or time.

CMS would allow separate payments for established patients for levels 1 through 5 and separate payments for new patients for levels 2 through 5. CMS proposes to adopt the Relative Value Update Committee (RUC) recommended values, times, and practice costs for the E/M office visits.

We commend CMS for listening to concerns and engaging with stakeholders over the past couple of years to refine the payment and coding approach for outpatient/office visits. **The AAMC strongly supports CMS' proposal to adopt the coding changes and payment rates for E/M services recommended by the RUC.** These changes will help to ensure that payment

more accurately reflects the resources used to provide services and to protect patient access. Our comments on specific elements of the proposal follow.

Finalize 2021 Policies to Allow Physicians to Select Visit Level and Documentation Based on Time or Medical Decision-Making

The AAMC supports finalizing the policy for 2021 that would allow physicians to select a visit level and document based on either medical decision-making or time, and the elimination of the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines. The original guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely independently. With the advent of the EHR, team-based care, and other changes over the past two decades, the E/M guidelines have become outdated and led to much of the "note bloat" that is seen in EHRs that has a negative effect on patient care. The current documentation requirements (such as noting review of systems) impose an onerous burden on physicians while providing little benefit to patients. In some cases, the requirements impede patient care by making it difficult to locate pertinent information such as physician's differential diagnosis or plan of care. The medical record was transformed from a document that enhanced patient care to one that focused on supporting billing.

Allowing physicians to document based on medical decision-making or time would help to alleviate these problems, lead to improved patient care, and better align with current medical practice and the use of electronic medical records.

Evaluation and Management Payment Proposals

Effective 2021, CMS would adopt the RUC-recommended values, times and practice costs for the E/M office outpatient visits. The RUC recommendations for physician work, time, and direct practice expenses would increase spending by $5.5 billion and contribute to approximately half of the budget neutrality adjustment proposed by CMS.

We support CMS' proposal to increase the values for the E/M services by adopting the RUC recommended values. One of CMS' goals is to support primary care and patient-centered care management by improving accuracy to recognize the costs of primary care management, coordination and cognitive services. The values in the current proposal recognize the increasing complexity of these services and the resources required to provide them.

CMS Should Maintain Relativity Between Services E/M Services and Services that are Analogous to Office/Outpatient E/M Visits

CMS recognizes that there are services for which the values are closely tied to the value of the office/outpatient E/M visit codes. Many of these services were valued via a building block methodology and have office/outpatient E/M visits explicitly built into their definition or valuation. CMS proposes to account for the increase in the values for the office/outpatient E/M visits in the following code families: 1) ESRD monthly capitation payment services, (2) transitional care management (TCM) services, (3) maternity services, (4) assessment and care

planning for patients with cognitive impairment, (5) Initial Preventive Physical Examination; (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits, (6) Emergency Department (ED) visits, (7) therapy evaluations and (8) behavioral health care services.

We support maintaining relativity between services, such as these code families, and E/M office visits in the fee schedule. CMS should ensure that there is an extensive review of services and additional surveys to determine appropriate values whenever making systematic adjustments to codes.

CMS Should Postpone Implementation of the Complexity Add-on Code (GPCIX) Until Further Information is Available on Impact

In addition to the changes to E/M codes, CMS proposes a new add-on code (GPCIX) that could be used when an office E/M service is performed, and the visit is considered to be a primary care visit, or when the medical services are part of ongoing care related to a patient's single, serious, or complex condition. Although CMS indicates that all physicians may report this code, CMS stated that for purposes of estimating the specialty level impacts, it assumed that the following specialties would bill GPCIX with 100 percent of their office/outpatient E/M visits codes: family practice, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonary disease. In total, CMS assumes the code would be applied to 75% of all office visit claims.

This add on code would increase spending by $3.3 billion, contributing to a significant portion of the budget neutrality adjustment proposed by CMS. **Given this major impact, we recommend that CMS postpone implementation of this add-on code until further clarification is provided on how it would be used and what the impact will be on payment and redistributions among specialties.** While we agree with the importance of ensuring physicians are adequately reimbursed for more complex patients, it is our understanding that the E/M codes were revalued to account for the complexity and resources required to provide these services. In addition, since the E/M code level can be determined by time, we think that the complexity will be reflected in additional time needed for providing the service and consequently a higher E/M code level for the visit. Therefore, we question whether the need for this add-on code still exists.

In addition, even if there is justification for the add-on code, we are concerned that it would add complexity to the system at a time when burden reduction is a key goal. We anticipate there would be significant confusion regarding when it would be appropriate to bill the add-on code. The addition of the code, which has a vague description, is likely to increase burden if there is a need to provide additional documentation to support the payment for the code. The documentation requirements could require extensive education for providers to comply and could potentially be as onerous as the current documentation requirements. Physicians are concerned that they may experience audits related to the use of this code.

If CMS implements this add on code in 2021, we urge CMS to reconsider its utilization assumptions which account for a significant portion of the decrease in the conversion factor. We believe it is unlikely that these codes will be reported 100% of the time with E/M office/visits for the identified specialties given feedback we have received from our members. In the past, CMS made assumptions regarding the utilization of TCM Codes (99495 and 99496) that were much higher than the actual utilization that occurred. As a result, CMS implemented budget neutrality adjustments that were too high in 2013. We caution CMS against making similar assumptions this time about codes that involve ongoing care and that would result in a significant permanent reduction in the conversion factor.

The AAMC also recommends that if CMS finalizes GPCIX, the agency not apply budget neutrality to that code since it is a new code established by regulation. We believe CMS has the authority to exclude changes in law and regulation, including the new add-on code, which affect spending from the calculation of budget neutrality, similar to treatment in the past under the Medicare Sustainable Growth Rate (SGR) system. For example, after Medicare preventive benefits were expanded, CMS increased the law and regulation factor of the SGR to account for the new benefits and excluded the additional spending for these new services from budget neutrality so that physicians were not penalized. While the SGR is no longer part of the law, it is illustrative of the application of budget neutrality not applying to new services paid for by Medicare as a result of changes in law or regulations. In this case, it is CMS that is modifying its regulations to create a new payment for E/M complexity that was not previously paid and, like any other new service with no predecessor, would not be subject to budget neutrality.

CMS Should Work with Stakeholders to Encourage Congress Waive Budget Neutrality for E/M Code Increases to Minimize Redistributive Effects

CMS provides an impact analysis of the E/M value changes proposed in Table 90 in the proposed rule.[1] The table allows insights into potential payment shifts across specialties that would result from implementing the updated values for the office E/M codes and the visit complexity add-on code (GPCIX).

While we support the increase in payment for the E/M services, we are deeply concerned about the redistributive impacts on specialties. Significant reductions in payment to some specialties could reduce access to medically necessary services and exacerbate workforce shortages. Because the PFS is budget neutral, any changes to the codes that increase the payment amounts under the fee schedule need to be offset by decreases elsewhere within the fee schedule. As CMS shows in the rule in Table 90, the E/M changes would benefit specialties that perform predominantly office visits and will result in reductions in payment for specialties that do not perform office visits. Specialty impacts range from -11% for radiology and nurse anesthetists/anesthesiologist assistants, to +17% for endocrinology.

The reductions would be very difficult for some specialties to absorb in their practices, particularly given the financial losses of approximately 25-50% incurred due to the COVID-19

[1] 85 Fed. Reg 50375.

pandemic and the fact that there are no payment updates in the fee schedule for six years from 2020-2025.

In addition, at a time when there are growing physician shortages, the shortages may be exacerbated for specialties that face significant cuts in payment. According to the AAMC's recently updated projections, by 2033 the country could experience a shortfall of between 54,100 and 139,000 physicians. Estimated shortages are predicted of 21,400 to 55,200 in primary care and between 33,700 and 86,700 in non-primary care specialties.[2] While significant concerns have been raised about primary care shortages, there are also growing shortages in many specialties, especially surgical ones. Absent a waiver of budget neutrality, access to participating physicians is likely to become a major concern.

As discussed previously in this letter, we urge CMS to work with the medical community and others to encourage Congress to waive budget neutrality for the E/M code increases and to take any other steps to mitigate this impact. If budget neutrality is not waived, we suggest CMS consider implementing a gradual phase in of the budget neutrality adjustment for the E/M codes over several years.

MEDICARE TELEHEALTH AND COMMUNICATION TECHNOLOGY-BASED SERVICES

The AAMC strongly supports the waivers and regulatory changes established by CMS in response to the COVID-19 public health emergency (PHE), which help to address the crisis caused by COVID-19 by facilitating the widespread use of telehealth and other communication technology-based services. Teaching hospitals, faculty physicians, and other providers have responded to the PHE 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 patients 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. At the onset of the COVID-19 pandemic, we heard from faculty practices that on average they were providing approximately 50% of their ambulatory visits via telehealth, a dramatic increase from the use of telehealth prior to the pandemic

The use of telehealth has been of great benefit for patients, especially during the public health emergency. It expands access to care for the frail or elderly, for whom travel to a provider or facility is risky or difficult even when there is no pandemic. Physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions. Telehealth also protects patient from exposure to infectious diseases, such as COVID-19 and the seasonal flu. The use of telehealth enables specialists, such as pediatric specialists and critical care physicians, to bring their skills to the bedside of a child or adult in need in hospitals in the community that do not have those specialists available onsite. But it must be recognized that the development of telehealth

[2] https://www.aamc.org/data-reports/workforce/data/complexities-physician-supply-and-demand-projections-2018-2033

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. Analyses of surveys of more than 30,000 patients conducted by Press Ganey for services in March and April 2020 show that patients are overwhelmingly positive about their virtual interactions with health care providers.[3] 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 due to statutory limitations most of the current flexibilities are in place only during the PHE. However, it is imperative that the progress that has been made since March 2020 continue when the PHE ends. **Therefore, we urge Congress and CMS to make changes to legislation and regulations that will allow the current changes to be made permanent while ensuring that reimbursement remains at a level that will support the infrastructure needed to continue provide telehealth services at a level far above that of the pre-pandemic world.** Comments on the specific provisions pertaining to telehealth and communications technology-based services included in the proposed rule follow.

CMS Should Waive Patient Location Restrictions and Rural Site Requirements

The AAMC strongly supports changes made in the CMS interim final rules related to the PHE that waived patient location restrictions that applied to telehealth services. Under this change, CMS pays for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home, during the PHE. This has allowed 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. It also means that patients who find travel to an in-person appointment challenging can receive care which may be particularly important to patients with chronic conditions or disabilities who need regular monitoring. The AAMC acknowledges that CMS does not have the authority outside of the PHE to make these changes permanent. **However, we encourage CMS to work with Congress to waive the rural site requirements and allow the home to be an originating site.**

Providers Should be Paid the Same Amount for Telehealth Services as Services Delivered In-Person

In the 2021 PFS proposed rule, CMS does not address payment rates for Medicare telehealth services. The AAMC strongly recommends that providers be paid the same for furnishing telehealth services as services delivered in person. In discussions with faculty practice plan leaders, members report significant infrastructure costs to fully integrate their electronic health record systems with HIPAA-compliant telehealth programs. Physicians employ medical assistants, nurses, and other staff to engage patients during telehealth visits and to coordinate care, regardless of whether the services are furnished in person or via telehealth. We

[3] Press Ganey, T*he Rapid Transition to Telemedicine: Insights and Early Trends* (May 19, 2020). https://www.pressganey.com/resources/white-papers/the-rapid-transition-to-telemedicine-insights-and-early-trends?s=White_Paper-PR

commend CMS for acknowledging these expenses in the March 31st interim final rule (85 Fed Reg 19320) by stating that telehealth services would be reimbursed to physicians at the non-facility fee schedule rate.

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. Similar to the physician office-based setting, the provider-based entity will continue to employ nurses, medical assistants, and other staff to engage patients during telehealth visits or to coordinate pre-or-post visit care. 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 May 8 (85 FR 27550), CMS decided to pay an originating site fee to recognize the costs incurred by hospitals.

CMS Should Continue to Allow Payment for Telehealth Services Delivered Across State Lines

As part of the COVID-19 PHE response, CMS has allowed providers to be reimbursed by Medicare for telehealth services across state lines. This waiver creates an opportunity to improve patient access to services and to help to improve continuity of care for patients that have relocated or who have traveled to receive their surgery or other services from a specialist in another state. While CMS has the authority to allow for payment, states need to act to allow practice across state lines to occur. **We urge CMS to continue this flexibility with regard to payment for services and to encourage states to participate in interstate medical licensure compacts or other mechanisms that would allow care delivery across state lines in the future after the pandemic ends**. **In addition, we urge CMS to support the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 4421, HR. 8283), which would provide temporary licensing reciprocity for health care professionals in all states for all types of services during the COVID-19 pandemic.**

Services Should be Added to the Medicare Telehealth List; Category 3 Should be a Permanent List as an Option to Add Services to the Medicare Telehealth List

In response to the PHE for COVID-19, CMS undertook emergency rulemaking to add a number of services to the telehealth list on an interim basis. Outside of the pandemic, CMS adds services to the telehealth list based on their similarity to other services already on the telehealth list (Category 1) or based on an assessment of whether the services would provide clinical benefit to the patient if provided by telehealth (Category 2). In this rule, CMS proposes a Category 1 list of codes that will be kept permanently on the telehealth list, including prolonged office codes and certain home visits. CMS proposes a new Category 3 group of services which would be included on the Medicare telehealth list until the end of the calendar year in which the PHE ends to allow more time to study the benefit of providing these services outside the context of the pandemic. This new Category 3 would provide a basis for adding or deleting services from the Medicare telehealth list on a temporary basis where there is likely clinical benefit, but where there is not yet sufficient evidence available to permanently consider the services under Category 1 or 2 criteria. CMS believes that adding services to the Category 3 list will provide sufficient time to develop clinical evidence to be used to request additions to the telehealth list on a permanent basis through the normal rulemaking cycle.

CMS also clarifies that some codes that had been billable during the PHE would not be billable once the PHE ends, either on a permanent or temporary basis. CMS solicits comment on services added to the Medicare telehealth list during the PHE for COVID-19 that CMS is not proposing to add to the Medicare telehealth list permanently or proposing to add temporarily on a category 3 basis.

The AAMC strongly supports the addition of the list of services identified in the rule under Category 1 and Category 3 to the Medicare telehealth list. We believe that experience during the COVID-19 pandemic has demonstrated the clinical utility of providing these services by telehealth and encourage the provision of telehealth services when clinically appropriate after the PHE ends. The placement of codes on the Medicare telehealth list allows physicians and other health care professionals and their patients to determine whether delivering a service via telehealth is clinically appropriate.

We support the establishment of Category 3 as an option to temporarily allow services to be billable, while the benefits are studied. However, we believe that the time frame proposed in the rule for coverage of Category 3 services is insufficient. Instead of linking it to the end of the calendar year in which the pandemic ends, we recommend that a defined time period be set, such as the end of 2022, for providers to collect data and perform analysis on the clinical benefit of the telehealth services. We also recommend CMS consider implementing the concept of Category 3 as a permanent option to allow potential Category 2 codes time to be considered a telehealth service and obtain sufficient evidence demonstrating the benefit of providing the service be telehealth.

The AAMC has significant concerns with the list of services that CMS is proposing to exclude from the telehealth list, either on a temporary or permanent basis, such as critical care services, inpatient neonatal and pediatric care services, initial nursing facility visits, and others. **We believe that adequate evidence exists about the value of these services, particularly in rural and other communities that do not have ready access to them. Therefore, the AAMC recommends that CMS allow all of these services to be provided by telehealth and enable further study.**

AAMC members provide these services by telehealth to enhance patient care, improve access, and provide high quality timely care. As an example, inpatient neonatal and pediatric care services, and other critical care services have been essential in the care of more complex patients in their community. Telehealth is increasingly being used to provide specialty consultants to infants, children, and adults receiving care in community and rural hospitals. It is often used for patients with unanticipated, urgent specialty needs, including newborn infants, and those presenting to emergency departments with acute medical emergencies. The use of this technology allows specialists to bring their skills to the bedside of the child or adult in need when travel to the specialist could delay care for many hours. The use of telehealth in these situations has shown to be life-saving and to reduce unnecessary patient transports.[4]

[4] https://pediatrics.aappublications.org/content/136/1/e293

Many academic medical centers have arrangements in place to provide care via telehealth to rural or community-based hospitals that do not have pediatric or neonatal critical care specialists, or pediatric intensive care units. When critically-ill infants are born, or when critically-ill children are admitted to their local hospital, the local physician is able to contact the academic medical center and have a pediatric or neonatal critical care physician provide an appointment, via telehealth, offering a diagnosis or other recommendations about care. This allows optimal care to be provided quickly and often this means that the local hospital is able to care for the patient. This saves resources, by removing the need for an expensive medical transport, and allows patients to stay in their community, close to family. While these services (CPT 99468-99472, 99475-99476, 99477-99480) are not generally provided to Medicare beneficiaries, the AAMC is concerned that if these services were added to a list of services specifically not permitted to be billed via telehealth, other payers such as Medicaid or commercial payers, may be disinclined to provide payment for them. This could lead to negative outcomes for critical patients and therefore we strongly encourage CMS to keep these important services on the Medicare telehealth list on a permanent basis.

Another example of effective use of telehealth services relates to physical therapy services, which CMS proposes not to add to the telehealth list. Hospitals that have been participating in bundled episodic payment models, such as BPCI Advanced, provide several physical therapy services to their patients following inpatient discharge to assess the home environment for any necessary safety accommodations, and to start the patient on their initial exercise program. After several telehealth visits, the patient is often able to go to outpatient therapy services for the remainder of their care. This avoids admission to a higher level of care setting, such as a skilled nursing facility, or home health agency, reduces costs, and increases patient satisfaction. We recognize that CMS decides not to include these services on the permanent telehealth list as it believes it does not have statutory authority to allow physical therapists, occupational therapists, and speech language pathologists to provide telehealth services. However, CMS does state that these services could be furnished by a therapist and billed by a physician or practitioner who can furnish and bill telehealth services provided all the "incident to" requirements are met. If CMS does not have statutory authority to add therapists as billing providers for telehealth, we recommend allowing the provision of these services in alternative payment models under its CMMI waiver authority.

AAMC Strongly Supports Continued Payment for Audio-only/Telephone-only Evaluation & Management Codes

In the March 31st COVID-19 IFC, CMS established separate payment for audio-only E/M services, CPT codes 99441-99443. CMS believes that these services, previously considered non-covered under the PFS, are an important way to replace a face-to-face visit during the PHE. CMS initially finalized payment based on the RVUs recommended by the RUC. Based on stakeholders' feedback, in the 2nd COVID-19 IFC,[5] CMS established new RVUs for the audio-only E/M services based on crosswalks to the most analogous office/outpatient E/M codes. In addition, CMS recognized these services as telehealth services and added them to the

[5] 85 Fed Reg 27550.

Medicare telehealth list for the duration of the PHE.

For audio-only E/M services, CMS issued a waiver of the requirements under section 1834(m) of the Act and its regulation at § 410.78 that Medicare telehealth services must by furnished using video technology. CMS is not proposing to continue to recognize these codes for payment under the PFS after the PHE. However, CMS acknowledges that the need for audio-only interaction could remain after the PHE as beneficiaries continue to avoid sources of potential infection. CMS seeks comments on whether it should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with a higher payment, and whether this should be a provisional policy to remain for some period after the PHE or if it should be a permanent PFS payment policy.

The AAMC strongly supports payment for the audio-only E/M codes after the PHE ends. Coverage of these audio only services 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 vulnerable populations, including the elderly, those with low socioeconomic status, certain races and ethnicities. Therefore, eliminating coverage for these important audio-only services will result in inequities in access to services for specific populations.

Data from the Clinical Practice Solutions Center (CPSC),[6] which contains claims data from 90 physician faculty practices, shows that approximately 30% of telehealth services were provided using audio-only telephone technology in April and May 2020 The proportion of telephone/audio-only visits increased with the age of the patient, with 17% of visits delivered via audio-only interaction for patients 41-60 years of age, 30% for patients 61-80 years of age, and 47% of visits for patients over 81. CMS also released data showing that nearly 1/3 of Medicare beneficiaries received telehealth by audio only telephone technology.[7] This demonstrates the importance of continuing to allow coverage and payment for telephone services for Medicare beneficiaries.

In addition, patients in rural areas and those with lower socio-economic status are more likely to have limited broadband access, making it more difficult to receive telehealth services by audio and video interactions. For these patients, their only option to receive services remotely is through a phone. Many services can be clinically appropriate when provided via an audio-only interaction, and that option should exist for patients.

The AAMC strongly recommends continued payment for audio only/telephone E/M services beyond the end of the PHE to patients who need telecommunications-based services in the home but do not have access to video connection or cannot successfully use

[6] The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, is the result of a partnership that works with member practice plasn to collect data on provider practice patterns and performance. This analysis included data from 65 faculty practices.

[7] ASPE Issue brief: Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic (7/18/2020); Health Affairs Blog; Early Impact Of CMS Expansion Of Medicare *Telehealth* During COVID-19. *Seema Verma*. July 15, 2020 (https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/abs/)

one. As an alternative to adding these services to the Medicare telehealth list, which has statutory requirements on the use of audio-video technology and originating site limitations, we encourage CMS to cover these telephone E/M services under the same authority it has used to pay for other communications technology-based services, such as virtual check- ins and remote technology. As part of its annual rulemaking for physician payments in the past, CMS has created payments for a number of telecommunications-based E/M services to patients in their homes, and in its first interim final rule on COVID flexibilities, CMS authorized payment for telephone- based E/M services using this authority.

Guardrails for Telehealth Services

In the 2021 Physician Fee Schedule proposed rule, CMS seeks feedback from stakeholders regarding guardrails surrounding telehealth and other communications technology-based services. The AAMC would welcome the opportunity to work collaboratively with CMS and other stakeholders to ensure that services provided via telehealth are clinically appropriate. To achieve this end it will be necessary to establish clinical guidelines for the provision of telehealth services, a framework to measure quality, privacy protections, and monitoring of utilization.

AAMC recommends that specialty societies and other organizations with telehealth expertise take the lead on determining best practices for telehealth, including clinical standards, guidelines, documentation, and expectations for clinicians and patients. This would include identifying conditions and circumstances for which telehealth is clinically appropriate and those for which it is not. Academic medical centers have been working within their specialty departments to establish guidance on when it would be ideal to deliver a service via telehealth and circumstances where the service needs to be provided in person. They are integrating these clinical algorithms into their scheduling systems so that patients are routed to the appropriate appointment type. Guidelines should also include expectations for the clinical encounter, including clinical and administrative staff involved in the encounter and the actions that should be taken before, during and after the visit.

Competencies and training for telehealth providers should also be implemented. The AAMC has recently published telehealth competencies[8] (AAMC Telehealth Advisory Committee, 2020). These competencies were developed by physician experts in telehealth clinical delivery models, experts in medical education, and patient advocates. They are intended to guide educators developing curricula as well as students learning to practice and professionals continuing their development. They focus on six domains; patient safety and appropriate use of telehealth, data collection and assessment via telehealth, communication via telehealth, ethical practices and legal requirements for telehealth, technology for telehealth, and access and equity in telehealth. We would be pleased to have CMS review the competencies and use them as an exemplar for telehealth providers.

In addition, we recommend establishment of a framework to measure quality, safety, timeliness, effectiveness, and patient experience with the use of telehealth. Examples of measures could include: appropriate diagnosis, increased ease of access, prescribing rates of medications or

[8] https://www.aamc.org/system/files/2020-09/hca-telehealthcollection-telehealth-competencies.pdf

ordering tests, cost of care and utilization, patient experience surveys, and patient-reported outcomes.

The AAMC encourages continued privacy protections under HIPAA for the use of telehealth. It will be important for CMS and HHS Office of Civil Rights (HHS OCR) to identify which technologies are permitted for patient data and patient-provider communication, and with what types of protections, and which should be prohibited. As telehealth is implemented, the AAMC encourages CMS and HHS OCR to actively monitor for practices that may be indicative of fraud and abuse and make provider education widely available.

Frequency Limitations for Inpatient and Nursing Home Services, and Critical Care Consultations Should be Relaxed

During the COVID-19 PHE, CMS waived the requirement for physicians and NPPs to personally perform required visits for nursing home residents and allowed visits to be conducted via telehealth. CMS seeks comment on whether it should maintain this flexibility on a permanent basis when the PHE ends and allow two-way, audio/video telecommunications for required nursing home resident visits when, due to continued exposure risks, or other factors, the clinician determines an in-person visit is not necessary. In this rule, CMS proposes to permanently revise the telehealth frequency limits for nursing facility visits from once every 30 days to once every 3 days. CMS should allow clinicians the discretion to decide the frequency of a telehealth visit for an individual patient. Clinicians practicing in skilled nursing facilities are caring for patients who are vulnerable, and it is important to reduce any unnecessary exposure or travel for these patients. Allowing for more telehealth services can also enable better access to specialists from other facilities. **The AAMC strongly supports relaxing the frequency limits on these nursing home telehealth visits.**

AAMC Supports Clarification of Policies for Telehealth Services Furnished in Same Building

The AAMC supports the clarification from CMS that services delivered using telehealth technology within the same building would be considered "in person" services. This allow an attending physician in one room of a hospital using telehealth to deliver care to a patient in another room that is considered "in person." **However, we recommend that CMS clarify that the same policy would apply to services furnished in separate buildings on the same campus**. Due to building configurations, there may be circumstances where the attending physician may be in a building adjacent to the building in which the patient is located, and this should be treated as an "in person' visit.

CHANGES TO THE TEACHING PHYSICIAN RULES; RESIDENT SUPERVISION

CMS Should Continue to Allow Virtual Supervision of Residents on a Permanent Basis

During the COVID-19 PHE, CMS adopted a policy on an interim basis that the requirement to bill Medicare Part B for the presence of a teaching physician during the key or critical portion of the service furnished with the involvement of the resident can be met using audio/video real-time communications technology. The policy generally requires real-time observation (not mere availability) by the teaching physician through audio and video technology during the key

portion of the service For the primary care exception (under section 415.174 c) CMS adopted a policy on an interim basis that would allow the teaching physician to direct the care furnished by the resident, and to review the services furnished by the resident during or immediately after the visit, remotely using audio/video real-time communications technology. CMS also adopted an interim policy during COVID-19 to allow payment to be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real time technology. A physician other than the resident must still review the resident's interpretation. CMS also adopted an interim policy allowing the teaching physician presence during the psychiatric service to bill Medicare Part B in which the resident is involved to be met using audio/video real time communications technology. CMS is considering whether these flexibilities should be extended on a temporary basis until December 31, 2021 or be made permanent after the PHE ends.

We commend CMS for adopting these virtual supervision policies as they have been critical in reducing exposure to COVID-19 and enabling expanded access to health care services. Continuing these policies will reduce risk exposure to all infectious diseases (e.g. coronavirus, seasonal flu, and others), increase the workforce capacity of teaching settings, increase access to care for patients, and allow important experience and training for the future physician workforce while appropriately supervised. **We recommend that CMS continue to allow these virtual supervision policies residents on a permanent basis**.

We believe that the teaching physician is able to exercise full, personal control over the management of the key portion of the care to bill Medicare Part B when the services are furnished by the resident with the teaching physician present through audio/video real time communications technology. The teaching physician should have the discretion to determine whether it is appropriate to be present virtually rather than in person depending on the services being furnished and the experience of the particular residents involved.

The AAMC supports the exclusion from direct supervision by interactive telecommunications technology to bill Medicare Part B for surgical, high risk, interventional and other complex procedures, endoscopies, and anesthesia services. For these services, we believe that the requirement for the physical, in-person presence of the teaching physician for the entire procedure or the key portion of the service with immediate availability through the procedure, is necessary for patient safety given the risks associated with these services. When providing these types of services, a patient's clinical status can quickly change and there is a need for the rapid onsite decision-making of the supervising physician.

While we understand CMS's concerns, we believe that guardrails exist through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations that have standards and systems that will ensure patient safety and oversight of residents when virtual supervision of residents occurs. ACGME sets forth extensive program requirements, including requirements related to supervision. ACGME recognizes that supervision may be exercised through a variety of methods, as appropriate to the situation, including through telecommunication technology. The program must demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and

ability guided by milestones, as well as patient complexity and acuity. The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. Teaching physicians are ultimately responsible for any adverse events that occur. ACGME, other accrediting organizations, and the medical education community work hard to monitor, report, and address any issues related to workload, patient safety, medical error, resident well- being and burn-out, professionalism, and resident learning and outcomes.[9]

Residents Should be Permanent Allowed to Provide Medicare Telehealth Services While Teaching Physician is Present Virtually

For the PHE, CMS permitted the use of audio/video real-time communications technology to establish the presence of a teaching physician when a resident furnishes telehealth services to beneficiaries in order to make payment under Medicare Part B for the services of the teaching physician. CMS is considering whether this policy should be extended on a temporary basis until December 31, 2021 or be made permanent once the PHE ends. In considering whether to extend or make this policy permanent, CMS expresses the same concerns and considerations as noted above related to virtual supervision. Additionally, the agency worries the different distant sites for the resident and teaching physician may prevent the teaching physician from being able to render sufficient personal and identifiable physicians' services to exercise full, personal control over the service to warrant a separate payment under the PFS.

We recommend that CMS allow residents to provide telehealth services permanently while a teaching physician is present via real-time audio-visual communications technology after the PHE ends. Resident education is a crucial step of professional development before autonomous clinical practice and requires varying levels of faculty supervision depending where the resident is in training and developing competency. **As part of this development, it is essential for residents to have the experience with telehealth visits while supervised as they will be providing them in the future to their patients when they practice autonomously**.

This change to CMS policy will improve patient access to care while also enhancing the resident's skills. As discussed above, ACGME supports the use of audio-visual communication devices by residents and their physicians. We believe that as long as the virtual presence of the teaching physician complies with the standards of ACGME and other accrediting organizations, teaching physicians, residents, and their patients will benefit from the provision of telehealth by residents.

AAMC Supports Permanently Allowing Residents to Moonlight in the Inpatient Setting, Provided ACGME Requirements are Met

In its March 31st COVID-19 IFC, CMS amended its regulations to state that during the PHE for COVID-19, the services of residents that are not related to their approved GME programs and are furnished to inpatients of a hospital in which they have their training program are separately

[9] ACGME program requirements (common program requirements residency) https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf

billable physicians' services for which payment can be made under the PFS provide that the services are identifiable physicians' services, the resident is fully licensed to practice medicine in the state where services are performed, and the services can be separately identified from those services that are required as part of an approved GME program. CMS is considering whether this flexibility should be extended to December 31, 2020 or be made permanent. **Provided that such moonlighting is consistent with accreditation requirements by ACGME, the AAMC supports permanently allowing residents to moonlight in the inpatient setting if the services are not related to their GME program. ACGME standards limit work hours to no more than 80 in a week, prohibit a first-year resident from moonlighting, and require that moonlighting not interfere with the resident's achievement of goals and objectives of the educational program. ACGME strictly monitors and enforces compliance with these requirements.**

To avoid any duplicate billing, we recommend that CMS educate providers about the need for sufficient documentation to support that these services provided are separate from those services that are required as part of the GME program. Allowing moonlighting will enable the teaching hospitals to ensure that there are qualified practitioners available to care for the patients during a public health emergency and also outside of a public health emergency, while maintaining the integrity of the graduate medical education programs.

AAMC Supports Expansion of Services Under the Primary Care Exception Policy

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 meet supervision requirements by being immediately available. In the March 31st COVID-19 IFC, CMS amended its regulations to allow, during the PHE for COVID-19, all levels of office/outpatient E/M visits to be included under the primary care exception. In the 2nd COVID-19 IFC, CMS further expanded the list of services included in the primary care exception during the PHE. CMS is considering whether to extend these policies on a temporary basis through December 31, 2021 or to make them permanent. CMS is particularly interested in whether the following codes should continue as part of the primary care exception; 99204, 99205, 99214, 99215, 99495, 99496, 99421, 99422, 99423, 99452, G2012, G2010.

The AAMC supports the expansion of the primary care exception (PCE) to include the services proposed by CMS. During the public health emergency, residents have demonstrated that they can competently provide these services. Residents will still be required to demonstrate competency in the services before they can utilize the primary care exception.

Level 4 and 5 E/M Services

We suggest if the teaching physician determines it is necessary, that the teaching physician be either physically present during the level 4 and 5 E/M services or be present in real-time through interactive technology. If the services provided are level 4 and 5, another teaching physician would need to be available to supervise other residents working under the primary care exception at that time. This would ensure that even if the teaching physician is present through interactive technology the PCE would otherwise be equivalent to what it was pre-pandemic.

Resident's Ability to Send Specialist Consult Requests (CPT 99452)

Based on significant experience that AMC's have had with residents providing interprofessional consults, the AAMC strongly supports inclusion of 99452 under the primary care exception beyond the PHE. Residents are trained on appropriate use of interprofessional consults and have demonstrated that they can place and manage these interprofessional consultations. Over the past 6 years, the AAMC has collaborated with 35 academic medical centers and children's hospitals through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional internet consultations, or eConsults. In the CORE model, eConsults are an asynchronous exchange in the EHR that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The model utilizes specialty and condition-specific templates to enable focused clinical exchanges between providers. A high quality eConsult includes a clear clinical question that can be answered with information available to the specialist in the EHR, and the response includes clear recommendations, a rationale and a contingency plan. There is an expectation that the specialist will respond within 72 hours; however, response times have averaged closer to 24 hours at most AMCs. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP.

Across our CORE AMCs, residents are trained on appropriate use of eConsults and place and manage these interprofessional consultations similarly to their work with referrals. In our CMMI HCIA pilot project, we found that approximately 65% of the more than 700 family medicine and internal medicine residents across the five pilot AMCs placed an eConsult at least once during the project period. As virtual care becomes an increasing part of general practice, it is important to allow residents to learn how to deliver optimal care in these new models and to bill for these services as do their attending physicians. Allowing residents to bill the service recognizes the time it takes to prepare the consultation and the responsibility that the resident will take in ongoing management of that patient's care, including implementing the specialist's recommendations and following up with their patient. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream visits and related costs.

During the COVID-19 PHE, CORE AMCs have found the eConsult to be a highly valued service by both providers and patients as it minimizes the risk of exposure and provides support to PCPs in managing their patients virtually. In addition, the eConsult is an asynchronous, provider-to-provider communication that does not rely on any additional technology and can be completed at the providers' convenience, enabling easy access to the service (and its benefits) for both patients and providers. In our evaluation of CORE through the CMMI HCIA project, we found that eConsults enabled timelier access to specialty input, led to a decrease in utilization of specialty services and costs, and resulted in positive patient and provider experience. Additionally, 86% of eConsults were resolved without a visit to that specialty in 90 days, saving patients out-of-pocket expenses and other costs, such as travel and time away from work. Enabling billing of this

service by residents beyond the PHE will help to further scale and sustain this valuable provider-to-provider clinical service.

Finally, the AAMC notes that if these changes to the primary care exception and supervision become final, it will be necessary for CMS to revise the provider manual instructions on teaching physicians.

REMOTE PHYSIOLOGIC MONITORING (RPM) SERVICES

CMS proposes to make permanent two of the interim changes in response to the COVID-19 PHE. First, CMS proposes to allow consent for RPM services to be obtained at the time that the services are furnished, rather than in advance. For CPT codes 99453 and 99454, CMS also proposes to allow auxiliary staff, which includes clinical staff and other individuals who are employees, or leased or contracted employees, to furnish services under the general supervision of the billing physician or practitioner.

CMS also offers clarification on two previously finalized policies. First, CMS clarifies that RPM services are captured by CPT codes 99453, 99454, 99091, 99457, 99458. CMS also clarifies that under 99454, the medical device supplied to the patient must digitally (i.e. automatically) upload patient physiologic data rather than using self-recorded and self-reported information from the patient. The CPT codebook guidance associated with 99454 only specifies that the device must meet the FDA's definition of a medical device as described in section 201(h) of the Federal Food, Drug, and Cosmetic Act. CMS offers this additional device requirement for billing via the Medicare program. The AAMC is very concerned that providers will have difficulty furnishing remote technology services in this future as the expense of technology that would enable electronic transmission of clinical information would be very high. Remote physiologic monitoring services help to keep individuals healthier and prevent hospital admissions or other adverse health events. Therefore, it is important not to set policies that are barriers to the provision of these services to patients. **We recommend CMS remove this requirement of electronic transmission and allow the patient to use low-tech devices and to separately report information to their providers.**

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

CMS proposes significant changes to the method for assessing, reporting and evaluating ACO quality under the Medicare Shared Savings Program (MSSP) and Merit-Based Incentive Payment System (MIPS). Changes proposed include elimination of the Web Interface, reducing the number of quality measures from 23 to six, and increasing the quality performance standard from the 30th percentile to the 40th percentile. At a time when ACOs are experiencing major challenges due to the COVD-19 PHE, a significant restructuring of the MSSP quality program will be difficult for ACOs to implement. More feedback should be collected before moving forward with such drastic changes. **While the AAMC understands CMS' desire to align the Shared Savings Program, and the MIPS program, and to modify the quality standards for ACOs, we encourage CMS to postpone for at least one year any changes to the current quality scoring program.** Comments on the specific ACO proposals in the rule follow.

CMS Should Maintain the Web Interface Reporting Option and Allow ACOs to Use Other Reporting Mechanisms

Beginning in 2021, without prior warning, CMS proposes to terminate the CMS Web Interface, which is the mechanism that ACOs use to report quality measures. If CMS terminates, the Web Interface in January 2021, ACOs would need to rapidly make changes to enable them to report using MIPS clinical quality measures using a registry or to report electronic Clinical Quality Measures (eCQMs) through their electronic health records (EHRs). **We urge CMS to maintain the Web Interface as a reporting option for ACOs while also allowing ACOs the option of using other reporting mechanisms.**

Making the switch to these alternative reporting options will cost many ACOs considerable time, money, and effort in changing workflows, paying for registries and adapting and modifying EHRs to comply with eCQM standards. Physicians and other health care professionals will need training to adjust to the new workflows. It is also important to recognize that ACOs use different approaches to combining clinical data across the ACO, which makes changes to reporting more challenging. Some ACOs have all of their participants on the same EHR platform, while others have participants that use multiple different EHRs. Clarity is needed on whether the ACO will be responsible for reporting MIPS CQMs or eCQMs for all of its participants or whether instead ACO participants will be able to report data directly to CMS to then aggregate for ACO scoring. This is critical for the ACOs with participants on multiple platforms, as it will be challenging to merge the data from the different EHRs to report MIPS CQMs or eCQMs. They will need to determine how to combine the data from each system, which will require the use of an outside vendor and will be costly.

We also recommend that additional time be provided to allow CMS to provide further clarification on how reporting MIPS CQM through registries will apply to ACO measurement, particularly with regard to benchmarks used and the population measured. Under the MIPS program, the benchmarks are determined separately for MIPS CQMs, eCQMs, and the Web Interface. CMS should clarify how the benchmarks would be set for MSSP ACOs when they use each of these reporting options. In addition, CMS should clarify whether ACO quality scoring would be based on patients that are assigned to the ACO or on all patients served by the ACO's participants. We recommend that the ACOs quality score be based only on the patients assigned to the ACO to accurately measure the ACO's quality efforts. The ACO does not have the same flexibilities to design care interventions for non-assigned patients and may not have the ability to access patient data for the non-ACO patients.

To give ACOs more time to prepare, and to allow CMS to develop and disseminate guidance on how this change will be operationalized, we urge CMS to provide a more gradual transition away from the use of the Web Interface reporting option. At a minimum, the Web Interface must be continued as a reporting option until at least the 2022 performance period to give ACOs sufficient time to implement a new reporting method.

CMS Should Seek Stakeholder Input Prior to Implementing Quality Measure Set

CMS proposes to apply the proposed APM Payment Pathway (APP) to ACO clinicians beginning with performance year 2021 as a successor to the APM scoring standard. The APP

measure set consists of 6 measures chosen to focus on population health and care delivered through APMs. MSSP ACOs would be required to report three measures (HbA1c Poor Control, Depression Screening and Follow-Up Plan, Controlling High Blood Pressure) and field the CAHPS survey. CMS would score the remaining two measures using administrative claims. The APP measure set would suffice for reporting under MIPS and, under the MSSP, the measure set also would be used to determine quality-based eligibility for sharing in any savings.

We appreciate the significant reduction in measures as it eases reporting burden. However, we recommend CMS seek stakeholder input prior to implementing this measure set for ACOs from the Measures Application Partnership (MAP) and others. The MAP is responsible for evaluating measures for the MSSP to ensure the measures fit the program prior to implementation. The MAP has not had the opportunity to review this measure set.

AAMC Recommends Maintaining the Pay-for-Reporting Year

CMS proposes to remove the pay-for-reporting year for ACOs beginning an initial MSSP contract as well as individual measures that are newly introduced to the measure set or measures that undergo significant changes. **We recommend CMS maintain the pay-for reporting year as it gives ACOs time to evaluate and make changes as needed to their processes, workflows, and other operations to ensure that their quality improvement initiatives are effective and that they are appropriately capturing quality data**. In addition, it is important to allow a pay for reporting year for new measures or measures with significant changes to ensure that there are no unintended consequences or flaws in the measure.

Update to Extreme and Uncontrollable Circumstances Policies

CMS proposes to update the extreme and uncontrollable circumstances policy under the MSSP consistent with its proposal to align the quality reporting requirements for MSSP with the proposed APP. Specifically, for performance year 2021 and subsequent performance years, CMS would set the minimum quality performance score for an ACO affected by an extreme and uncontrollable circumstance during the performance year to equal the 40th percentile MIPS Quality performance category score. **AAMC supports this update**.

AAMC Supports Expanding the Definition of Primary Care Services Used in MSSP Assignment

CMS proposes to expand the definition of primary care services used to determine MSSP assignment in its regulations to include the following additions beginning January 1, 2021:

- online digital evaluation and management CPT codes 99421, 99422, and 99423;
- assessment of and care planning for patients with cognitive impairment CPT code 99483;
- chronic care management code CPT code 99491;
- non-complex chronic care management HCPCS code G2058 and its proposed replacement CPT code, if finalized in this CY 2021 PFS rulemaking;
- principal care management HCPCS codes G2064 and G2065; and

- psychiatric collaborative care model HCPCS code GCOL1, if finalized in this CY 2021 PFS rulemaking

The AAMC supports the addition of these services to the primary care services used for MSSP assignment and also recommends the addition of G2010 and G2012 to the list.

QUALITY PAYMENT PROGRAM

The AAMC appreciates CMS's efforts to build on the first few years of implementation of the Quality Payment Program (QPP). We support CMS's plan to continue to develop Quality Payment Program policies that more effectively reward high-quality care of patients and increase opportunities for Advanced APM participation. We commend CMS's efforts to support clinicians on the front lines during the COVID-19 pandemic by providing burden relief through the extreme and uncontrollable circumstances policy. We appreciate CMS's plan to limit 2021 performance year proposals in light of the COVID-19 pandemic to promote program stability and lessen distractions as clinicians respond to the pandemic. **The AAMC recommends that all measures used in the quality payment program be appropriately adjusted to account for the clinical and social complexity of patients. We encourage CMS to work with key stakeholders to identify longer term policy solutions in the future that would attain health equity for all beneficiaries and minimize unintended consequences.** Our comments on the proposals in the rule related to the QPP follow.

MIPS VALUE PATHWAYS (MVPS)

In the 2020 PFS final rule, CMS established a new MIPS participation framework, referred to as MIPS Value Pathways (MVPs), that would begin with the 2021 performance year; however, due to the COVID-19 public health emergency CMS proposes to delay MVP implementation until at least 2022. CMS intends to implement the MVP while maintaining the other "traditional" MIPS participation options. CMS indicates that traditional MIPS will be maintained while a robust inventory of MVPs is built but expects to propose thereafter that all MIPS eligible clinicians would be required to participate in MIPS via an MVP or an APM Performance Pathway.

The AAMC strongly supports CMS's proposal to delay implementation of the MVPs. Clinicians are on the frontlines treating COVID-19 patients. Now is not the time to burden clinicians with learning a new method of reporting under the MIPS program. The MVPs should be gradually implemented to ensure that they are meaningful for clinicians and their patients and not burdensome to report.

CMS Should Address the Unique Challenges Posed for Large Multi-Specialty Practices Reporting MVPs

In the proposed rule CMS includes revised principles for MVPs. CMS notes that the revised second principle responds to repeated stakeholder requests, particularly from multispecialty groups, that MIPS be changed to allow data submission by subgroups within a TIN. **We appreciate CMS's recognition of the importance of allowing a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup than to the larger group, and to be assessed and scored based on the subgroup's**

performance. We encourage CMS to provide information regarding how this would be operationalized, particularly how subgroups can form and opt-in to MVPs.

As CMS considers how MVPs would be operationalized, it is important to understand the unique challenges posed by the QPP for large multi-specialty practices. AAMC members include academic medical centers in which faculty physicians are frequently organized under a single tax identification number (TIN). Recent data shows that the practice plans range in size from a low of 128 individual National Provider Identifiers (NPIs) to a high of 4, 319 with a mean of 989 and a median of 816. On average these practices often have over 70 adult and pediatric specialties and numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases, faculty practice plans are highly integrated and make decisions about quality and care coordination as a single entity. In other instances, such decision-making occurs at the specialty level.

With the large number of distinct specialties reporting under one TIN, it will be very challenging to identify MVPs that will be meaningful for all the different specialties in the practice. Even if multiple MVPs are selected for reporting, it will still be difficult to identify MVPs that describe the scope of conditions treated and vast number of specialties included in academic medical centers. If multiple MVPs are reported and scored at the group level, we question whether the information provided will be useful to consumers and whether it will drive improvements in performance.

The AAMC continues to believe that a better solution is to have subgroup identifiers to allow reporting and performance measurement at the subgroup level. Specifically, to allow participation in MIPS at a subgroup level, the AAMC recommends that CMS follow some of the policies set forth for virtual groups[10], which include:

- Establish a subgroup identifier.
- Require the subgroup to make an election prior to the start of the applicable performance period under MIPS to be a subgroup.
- Request that a list of participants who would be part of the subgroup identifier be provided to CMS. A subgroup would submit each TIN and NPI associated with the subgroup, the name and contact information for a subgroup representative and a confirmation that each member of the subgroup is aware of their participation.
- Identify each MIPS eligible clinician who is part of the subgroup by a unique subgroup participant identifier which would be a combination of 1) subgroup identifier (established by CMS); 2) TIN; and 3) NPI.

Depending on the practice, there are advantages and disadvantages to reporting under a subgroup MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome. We recommend that physicians who are not affiliated with the subgroup that is participating in an MVP retain the option to participate as a group

[10] 42 CFR 414.1315

practice in traditional MIPS. As a model, CMS could consider its "split-TIN" policy that applies to certain Advanced APMs, such as Next Generation, where some of the groups clinicians participate in the model while others do not. Under MIPS, the clinicians in the group that are not in the model are able to participate under MIPS using a different data submission than those who are participants in the Advanced APM.

ELIMINATION OF MIPS APM SCORING STANDARD AND ALTERNATIVE PAYMENT MODEL PERFORMANCE PATHWAY (APP)

CMS proposes significant changes related to MIPS APMs. Currently, eligible clinicians in a MIPS APM participate in MIPS through their APM entity under the APM scoring standard. The MIPS APM scoring standard was designed to reduce burden and increase meaningful measurement for MIPS eligible clinicians participating in MIPS APMs who do not reach Qualified Participant (QP) status and thus remain subject to MIPS reporting for a performance year, thereby encouraging their continued APM involvement. CMS proposes to terminate the MIPS scoring standard. In its place, CMS proposes to add the APM Performance Pathway as a new option for MIPS reporting and scoring for the clinicians in these MIPS APMs. Alternatively, eligible clinicians in the APM could report through any other MIPS reporting option and be scored under the general MIPS standards.

AAMC recommends CMS maintain the MIPS APM Scoring Standard and not require a transition to the APM Performance Pathway (APP). The MIPS APM Scoring Standard allows each APM to have its own set of unique quality measures and scoring approaches that best fit the particular model. This approach allows specific APMs to report on meaningful quality measures tailored to their model. The proposed APP approach would apply one set of 6 quality measures for all APMs subject to MIPS. From a clinical perspective it does not make sense to measure the MIPS performance under the Oncology Care Model using the same set of measures that apply to an ACO.

Each model participant would need to report their APM's specific quality measures, and the APP quality measures, which may not be clinically meaningful for their model. CMS should maintain the APM Scoring Standard at this time to limit burden and continue to encourage MIPS eligible clinicians to join APMs. APM entities and associated physicians are on the frontlines addressing challenges due to COVID-19; now is not the time to make such significant changes to MIPS APM scoring.

MERIT-BASED INCENTIVE PERFORMANCE SYSTEM (MIPS)

MIPS Performance Category: Quality

For the 2021 performance year, CMS proposes to set the quality performance weight at 40%, a 5% decrease from 2020. CMS still requires reporting of six quality measures, including one outcome or high priority measure. As in the past, there are several ways to report quality. Eligible clinicians can choose to report a minimum of six measures and one of those six measures must be an outcomes measure or a high priority measure. Notably, CMS is proposing to terminate the GPRO Web Interface reporting options. CMS is proposing substantive changes

to 112 existing quality measures, changes to specialty measure sets, and removal of 14 quality measures. CMS is also adding two administrative claims outcomes quality measures.

The AAMC Recommends Maintaining the Quality Category Weight

CMS reduced the weight of the quality measure to 40% to account for the 5% increase in the cost measure category weight proposed in the rule. We have significant concerns regarding attribution and risk adjustment of the cost measures. In addition, the COVID-19 pandemic will have an impact on the benchmarks and performance on the cost measures. **The AAMC recommends that CMS maintain the weight of 45% for the quality performance category for the 2021 performance year to provide additional time to address concerns with the cost measures.**

AAMC Recommends Maintaining Existing MIPS Quality Measures

The AAMC has concerns with the removal of additional quality measures. Removing measures creates a lack of consistency of available measures in the program, which prevents CMS from measuring practices on improvement. It also impedes practices from focusing on applying improvement strategies and reduces the number of measures available to form MIPS Value Pathways (MVPs).

Faculty practices invest time and resources to implement quality measures and update their systems. **We recommend maintaining the existing MIPS quality measures to ensure consistency, reduce a burden, and allow options in the future for MVPs.** Removing or changing measures forces a practice to pick new measures to satisfy MIPS requirements, requiring changes to systems and more education to clinicians. It also affects the ability to document and track performance improvement. Annual program changes increase administrative burden, add to complexity and cost of the program, and run counter to the Agency's Patients Over Paperwork Initiative.

AAMC Supports Use of Performance Year Benchmarks for 2021

CMS states that due to COVID-19, it intends to use performance period benchmarks instead of historic benchmarks for the CY 2021 performance period. Thus, benchmarks for the CY 2021 performance period would be based on the actual data submitted during the CY 2021 performance period instead of using baseline data from 2019. Due to COVID-19 flexibilities regarding data submission, it is likely that CMS may not have as representative of a sample of data as it would have had absent the pandemic. **We support CMS's proposal to use performance year benchmarks for 2021 to ensure more accurate and reliable data. This will better capture any changes in care that have occurred as a result of COVID-19**.

CMS Should Provide A Gradual Transition Away from GPRO Web Interface Reporting Option

The AAMC strongly disagrees with CMS' proposal to sunset the Web Interface reporting option. Many faculty practice plans report quality in the MIPS program via the Web Interface. Eligible clinicians will now need to use a different reporting mechanism. It will take considerable time, money, and effort to change workflows, pay for registries, and adapt and modify EHRs to comply with eCQM standards. **For these reasons, we strongly urge CMS to provide a gradual**

transition away from the use of the Web Interface reporting option. More time and thought must be given regarding how this will be implemented, and for group practices to assess their alternatives. At a minimum, the Web Interface must be continued for at least one additional year to give sufficient time for affected practices to implement a new reporting method.

MIPS Performance Category: Cost

For the 2021 performance year, CMS proposes to weight the cost category at 20%, an increase from the 2020 weight of 15%. **Given the multiple concerns under the cost category, including the impact of COVID-19 on patterns of care, clinicians' lack of familiarity with cost measures, the need for risk adjustment, and the need for better attribution methodologies, the AAMC strongly urges CMS to continue the weight of the cost category at 15**%. Our concerns are enumerated in further detail below.

Cost Category Measures

For 2021, CMS plans to assess performance in the cost category by utilizing: 1) the Total Per Capita Cost of Care (TPCC) measure; 2) the Medicare Spending Per Beneficiary (MSPB) measure; and 3) 18 episode-based cost measures. The AAMC is concerned about the cost measures used to measure clinician's performance, particularly given the challenges with attribution and risk adjustment, which need further study.

All Cost Measures Must be Appropriately Adjusted to Account for Clinical Complexity and Social Risk Factors

The AAMC recommends that all cost measures used in the MIPS program be appropriately adjusted to account for clinical complexity and social risk factors. The 18-episode cost measures are risk-adjusted based on variables, such as age and comorbidities by using Hierarchical Condition Categories (HCC) data and other clinical characteristics. While the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per Beneficiary (MSPB) measures are risk adjusted to recognize demographic factors, such as age, or certain clinical conditions, these measures are not adjusted for other social risk factors. In addition to differences in patient clinical complexity, social risk factors can drive differences in average episode costs. A recent report from the National Academies of Science, Engineering and Medicine[11] clearly acknowledged that sociodemographic status variables (such as low income and education) may explain adverse outcomes and higher costs.

The COVID-19 pandemic has demonstrated the importance of accurate risk adjustment. The virus has a disproportionate impact on racial and ethnic minorities, the homeless, individuals in long-term facilities, the elderly, and those with underlying conditions. Literature has shown that patients who are already at high-risk due to social factors are at further risk of serious illness related to COVID-19.[12]

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[11] National Academies of Sciences, Engineering, and Medicine. *Accounting for social risk factors in Medicare payment: Criteria, factors, and methods*. The National Academies Press. 2016. Doi: 10.17226/23513.
[12] Koma, W. et al. *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*. Kaiser Family Foundation. May 7, 2020. Available at: https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/

Without accurately accounting for clinical complexity, social risk factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately represented to patients. Physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

The AAMC believes that there are ways to appropriately incorporate patient complexity and social risk factors in the risk adjustment methodology. We request that these measures be adjusted to account for these risk factors.

Attribution Method Should be Clear and Transparent and Accurately Determine Patient/Clinician Relationship

It is critical that when measuring costs there be an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from numerous clinicians across several facilities and teams within a single practice or facility. The attribution method should be clear and transparent to clinicians. We suggest that better data sources and analytic techniques should be explored in the future to support more accurate attribution of these episodes. Attribution is a key component of these cost measures.

Cost Measures Feedback

As cost measures are still being developed and implemented, clinicians need to gain more familiarity and experience with them before they represent a greater portion of the MIPS final score. Physicians have only received feedback reports on their attributed patient population and cost measure performance for CY 2018 and CY 2019. In CY 2019 the first wave of episode-based cost measures went into effect and in 2020 CMS added 10 new cost measures. Additionally, CMS significantly revised the total per capita cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures in 2020. These major changes occurred in 2020 at a time when physicians had to focus their attention on treating patients with COVID-19, implementing telehealth, obtaining PPE, and addressing financial challenges due to loss of revenue. Physicians need time to closely review feedback to determine the extent of unwarranted variation in spending and understand their patterns of care. Reports with detailed actionable data on performance on the cost measures are essential for providers to determine how they are performing, how they compare to other providers, and to identify what improvements they need to make.

Beyond the individual clinician reports, we also recommend that CMS analyze their aggregate data for each cost measure and release the data and their analysis publicly on an annual basis. This will enable an assessment of whether the cost measures are working as intended.

The Impact of COVID-19 On Cost Measures Needs to be Explored

Since cost measures performance is based on national average benchmarks, we are concerned that physicians and practices that have been on the frontlines treating COVID-19 patients will be unfairly penalized. Physicians treating COVID-19 may have patients that are more likely to have

complications, admissions and readmissions due to the COVID-19 pandemic which may cause these physicians to receive lower scores on cost measures. It also is possible that the PHE may cause disruptions to attribution, reliability and validity. **We recommend that CMS explore the impact of COVID-19 on cost measures and determine adjustments that are needed before increasing the weight of the cost performance category**. **We urge CMS to reweight the cost category to zero when cost performance is impacted due to factors that are outside the control of the physicians, such as a PHE.**

CMS Should Address Ongoing Concerns with Medicare Spending Per Beneficiary (MSPB) Measure and Total per Capita Cost Measure (TPCC)

Despite concerns previously raised by many stakeholders, including AAMC, CMS included the revised MSBP and TPCC measures for MIPS in the 2020 physician fee schedule final rule. While we appreciate CMS' efforts to refine this measure, significant concerns remain. For cost measures, an accurate determination of the relationship between a patient and a clinician is critical to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated since most patients receive care from numerous clinicians across several facilities. The MSPB measure and the TPCC measures holds physicians accountable for costs related to patients' medical conditions that are managed outside of their organization, and for costs they cannot control, such as drug prices. The measures also fail to risk-adjust for SDS. In addition, the measures capture the same costs as the episode-based measures, effectively "double counting" the costs. Attribution, benchmarks, and risk adjustments for both measures also need to be reexamined in light of the COVID-19 pandemic.

The National Quality Forum (NQF) Cost and Efficiency Standing Committee reviewed these measures in July 2020 and recommended not to endorse the MSPB clinician measure for MIPS and did not reach consensus on the TPCC measure due to serious concerns with the measure.[13] **In light of the NQF recommendations, issues raised by stakeholders, and the impact of COVID-19 on these measures, we recommend that CMS address the ongoing concerns with the validity, reliability and risk adjustment for the MSBP and TPCC measures.**

MIPS Performance Category: Promoting Interoperability

For the 2021 performance year, the weight for the Promoting Interoperability (PI) category remains unchanged at 25%. CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) measure and make minor changes to the name of the Health Information Exchange Objective measures.

CMS Should Maintain Query of Prescription Drug Monitoring Program (PDMP)

Specifically, CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) as an optional measure and is eligible for 10 bonus points for 2021. This decision was made due to several challenges that have been identified with implementing this measure, including difficulties in implementing it in EHR clinical workflow and state variations in PDMP structure.

[13] NQF Cost and Efficiency Standing Committee Draft Report – Spring 2020 Cycle. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=93518

The AAMC supports maintaining the PDMP measure as voluntary and providing a 10-point bonus if reported. The AAMC recognizes the value of new tools to assist with the opioid addiction epidemic but cautions against making this measure required until the measure is more clearly defined and there is better evidence of integration of these tools in CEHRT by vendors and into clinical workflows.

AAMC Supports Addition of Health Information Exchange (HIE) Bi-Directional Exchange Measure

CMS proposes to add a new measure beginning with the 2021 performance period: *Health Information Exchange (HIE) Bi-Directional Exchange.* Clinicians would be able to attest to this measure in lieu of reporting the two existing measures *Support Electronic Referral Loops by Sending Health Information* and *Support Electronic Referral Loops by Receiving and Incorporating Health Information.* The new measure would be worth 40 points, the maximum allowed under the Health Information Exchange Objective of the Promoting Interoperability category. CMS proposes to limit the bi-directional measure to exchange with unaffiliated entities and between disparate EHRs.

The AAMC supports the addition of this new alternative measure to the HIE objective and reporting with a yes/no attestation method. We share CMS's goal of achieving interoperability and believe this measure will encourage physician participation in bi-directional exchange via HIEs. To maximize HIE participation, we recommend that CMS limit the proposed bi-directional measure conditions to exchange between unaffiliated entities regardless of whether they are using the same EHR product. We also recommend that CMS revise the attestation language proposed to ensure that the attesting clinician is not being held accountable for some features of his/her HIE that she might not know about or have control over.

AAMC Supports Doubling of Complex Patient Bonus for 2023 Payment Year

CMS is required by statute (section 1848(q)(1)(G)) to consider risk factors in the MIPS scoring methodology. In CY 2018, CMS established a complex patient bonus of up to 5 points to be added to the final score for the 2020 MIPS payment year and continued this complex patient bonus in the 2021 and 2022 MIPS payment years. CMS proposes to continue the bonus for the 2023 payment year. CMS determines eligibility for the complex patient bonus by measuring medical complexity through Hierarchical condition Category (HCC) risk scores, and social risk as measured through the proportion of patients with dual eligible status. CMS proposes to double the patient complex bonus amount (not to exceed 10 bonus points) for the 2020 performance period due to the effects of COVID-19 on patients.

We support doubling the complex patient score to account for the difficulty of managing complex patients during the pandemic. It is important that a clinician not be penalized as a "poor performer" when the underlying issue is that the clinician is caring for increasingly complex patients due to COVID-19.

We support the continuation of the complex patient bonus for the 2023 payment year. However, we encourage CMS to identify approaches other than HCC scores and dual eligible patient status to better represent the clinical and social complexity of patients. We recommend that CMS work with key stakeholders to identify longer term policy solutions

in the future that would attain health equity for all beneficiaries and minimize unintended consequences.

ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMS)

CMS Should Encourage Congress to Grant Authority to Set Thresholds at a Level That Would Encourage Participation

To be classified as a qualifying participant (QP) or partial qualifying participant in an APM, providers need to meet or exceed thresholds based on patients seen or payment received for services provided through APMs. These thresholds, which were established by Congress, have been increased since the start of the program. For the payment years 2023 and beyond, clinicians will need to have at least 75% of their revenue in the Medicare FFS program received through a Medicare APM, or 50% of their Medicare FFS patients need to receive services through the APM, in order be considered a QP. These thresholds are significantly higher than they were for the 2020 performance year which will make it much more difficult for an eligible clinician to be considered a QP and to receive the 5% bonus payment in 2023.

The AAMC is concerned that the increasing thresholds that must be met to be considered qualified participants in an advanced APM will discourage participation, thereby limiting beneficiary access to high quality and better coordinated care. It is very difficult for APMs to increase the amount of payments received through the APM or amount of Medicare FFS patients who receive services through the APM. For example, it is especially difficult for ACOs in rural areas and those that include specialists since primary care determines ACO assignment. A recent survey by National Association of Accountable Care Organizations (NAACOS)[14] found that 96% of the 216 ACO respondents would not meet the 2021 thresholds based on their performance in 2020. CMS recently released data showing that, on average, providers missed the current 50% CP threshold and were not close to reaching the 75% threshold required for the 2021 performance year. The 2018 QPP Experience Report published by CMS shows that the average payment score for Medicare Shared Savings Program accountable care organizations (ACOs) was 44%, and the average patient score was 45%. Even more concerning, the average threshold scored for the Comprehensive Care for Joint Replacement Model was 12 for payment and 5% for patients. The COVID-19 pandemic will make it even more challenging for APMs to meet these thresholds due to shifts in practice patterns.

We recommend CMS support efforts by the provider community to convince Congress to make changes that would give CMS the discretion to set the thresholds at an appropriate level that encourages advanced APM participation. While CMS may not have authority to adjust the payment threshold, we believe CMS has authority to maintain a lower patient threshold and urge CMS to do so.

In the rule CMS includes a proposal to make it easier for eligible clinicians to meet the thresholds. For 2020 the threshold scores are calculated as a ratio of patients attributed to the ACO to attribution-eligible patients. CMS has found that when beneficiaries are prospectively attributed to an APM (e.g., Next Generation ACO model), they may still be counted as attribution-eligible in some APM Entities for which attribution is retrospective. As a result, the

[14] https://www.naacos.com/press-release--naacos-survey-shows-potential-halt-to-value-based-payment-incentives

denominator for the retrospective-attribution entity would be artificially inflated and make it more difficult for the entity's clinicians to meet QP thresholds and receive bonus payments. CMS proposes to resolve this problem by removing prospectively-attributed beneficiaries from the denominators of threshold score calculations made for entities that align beneficiaries retrospectively. **We support the update to the methodology for calculating the QP thresholds by excluding these prospectively attributed beneficiaries**.

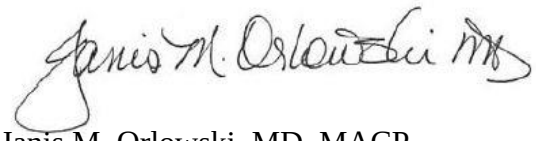
Make Timely Distributions of 5% Advanced Alternative Payment Model Bonus

To encourage participation in advanced Alternative Payment Models in the future, the AAMC urges CMS to make more timely payments to providers that qualify for the 5% bonus. There have been delays in receiving bonus payments under the program. Many academic medical centers made significant investments to participate as advanced APMs, including hiring additional staff to improve care coordination and investing in new technologies to support advanced care processes and performance data submission. They took on financial risk with an expectation that some of these investments would be recouped in part by the 5% advanced APM payments.

CONCLUSION

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org or Kate Ogden at kogden@aamc.org.

Sincerely,



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