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Submitted via the Federal eRulemaking Portal: <http://www.regulations.gov>

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Medicare and Medicaid Programs; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program [CMS-5531-IFC]

Dear Administrator Verma:

America's Physician Groups (APG) appreciates the opportunity to comment on the Interim Final Rule on Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE) and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program. Our members strongly support your efforts to address the many issues arising within physician groups during this public health emergency to provide relief for providers.

About America's Physician Groups

APG is a national professional association representing over 300 physician groups that employ or contract with approximately 195,000 physicians that provide care to nearly 45 million patients. Our tagline, "Taking Responsibility for America's Health," represents our members' vision to move from the antiquated fee-for-service (FFS) reimbursement system to a value-based system where physician groups are accountable for the cost and quality of care. Our preferred model of capitated, delegated, and coordinated care eliminates incentives for waste associated with FFS reimbursement. APG member organizations are working diligently to rise to the challenge presented by the COVID-19 pandemic. We are focused on the transition of most patient visits to telehealth as a best practice in slowing the spread of the virus and keeping patients safe.

Summary of APG's Recommendations

- **Consider analyzing data from both 2019 and 2020 years in determining 2021 attribution**
- **Implement the MSSP extreme and uncontrollable circumstance policy through December 2020**

- **Continue reimbursement parity for audio-only telehealth after the PHE, where statutorily allowable**

Comments

Scope of Practice

CMS ruled that it will allow nurse practitioners (NP), certified nursing specialists (CNS), physician assistants (PA), and certified nursing midwives (CNM) the flexibility to supervise diagnostic testing to the extent authorized by their State's scope of practice laws.

APG welcomes the added flexibility for non-physician practitioners during a time of increased need for healthcare professionals. The community public health need is still great and as providers and organizations continue to make investments to best serve patients during this pandemic, it is important that healthcare organizations also have the necessary workforce numbers to accommodate potential patient increases due to COVID-19. This regulation ensures a stable stream of providers on hand that will decrease the burden on physicians and allow for a strong and effective public health response.

Rural Health Clinics

CMS implemented, on a temporary basis, a change to the period used to determine the number of beds in a hospital for purposes of determining which provider-based rural health clinics (RHC) are subject to the payment limit. During the PHE, CMS will use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count. RHCs with provider-based status that were exempt from the national per-visit payment limit in the period prior to the effective date of the PHE continue to be exempt for the duration of the PHE for the COVID-19 pandemic.

APG applauds the move by CMS to allow rural health clinics to increase their bed capacity without affecting their payments. This change will allow facilities in underserved locations where facilities may be sparse to create capacity to account for any surges in patients that may occur due to COVID-19. As CMS has established multiple initiatives in support of rural healthcare in the wake of the COVID-19 pandemic, ensuring that patients who reside in rural areas of the country have access to care throughout the entirety of the PHE is an integral part of that effort and one that this policy will heavily support.

Care Planning for Medicare Home Health Services

The CARES Act allowed NPs, CNSs, and PAs to certify eligibility for home health services, as well as establish and periodically review the home health plan of care. CMS explains that HHAs or other practitioners should check with the relevant state licensing authority websites to ensure that practitioners are working within their scope of practice and prescriptive authority. In the second interim final rule, CMS defined NPs, CNS, and PAs as "allowed practitioners." An "allowed practitioner" may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit. Allowed practitioners may also perform the face-to-face encounter for the patient for whom they are certifying eligibility; however, if a face-to-face encounter is performed by an allowed non-physician provider (NPP) in an acute or post-acute facility, from which the patient was directly admitted to home health, the certifying practitioner may be different from the provider

performing the face-to-face encounter. These changes will become permanent and are not time limited to the period of the PHE.

The expansion of eligible practitioners during the PHE is needed and a policy that APG applauds. By allowing providers to deliver care with minimal geographic or physical restrictions where possible, physician providers receive much needed assistance in dealing with patient surges and a lessening of their supervisory and administrative burdens at a time where surges in the number of patients needing assistance are occurring. The expansion of allowable activities for non-physician providers also allows for an immediate expansion of healthcare workforces with seasoned, experience professionals who are capable of treating patients and working in tandem with physicians when needed.

CARES Act Waiver of the “3-Hour Rule” and Modification of IRF Coverage and Classification Requirements for Freestanding IRF Hospitals for the PHE During the COVID-19 Pandemic

The CARES Act required the Department of Health and Human Services (HHS) to waive the “3-Hour Rule” during the PHE. In the second interim final rule, CMS has rescinded its previous waiver of the 3-hour rule to reflect that it is superseded by the CARES Act and clarifies that rule is waived regardless of whether a patient was admitted for standard IRF care or to relieve acute care hospital capacity.

APG again reiterates its support of waiving the 3-hour rule as well as CMS’ clarification that the rule is waived for both standard IRF care and for the purpose of relieving hospital capacity for acute care. The clarification will allow IRFs to support acute-care hospitals with earlier transfer to post-acute rehabilitation and create unoccupied hospital beds in acute-care settings for patients at a time where hospital beds are at a premium, adding critical capacity for the healthcare system.

Medicare Shared Savings Program

CMS has modified numerous Medicare Shared Savings Program (MSSP) policies to address the impact of the COVID-19 PHE and encourage continued participation by Accountable Care Organizations (ACOs). The changes include allowing ACOs whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement period by one year; allowing ACOs in the BASIC track to elect to maintain their current level of participation for performance year (PY) 2021; clarifying the applicability of the program’s extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the PHE; adjustments to program calculations to mitigate the impact of COVID-19 on ACOs; and expanding the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication.

APG applauds CMS’ decision to allow individual organizations to choose to extend their agreement period and for ACOs in the BASIC track to maintain their current level of participation. These options give each organization the opportunity to choose the path most conducive toward success for their specific circumstance. For some organizations, losing the opportunity to share in savings would only compound the financial hardships they are currently experiencing due to COVID-19 while others may need to delay reconciliation for the time being

in order to stave off their financial hardships while maintaining their long-term commitment toward transforming our current system on the path to value.

The nature of this pandemic has resulted in atypical patterns of care that will make attribution for ACO patients increasingly difficult. This could result in significant changes in an ACO's attributed beneficiaries that would have a negative impact on provider organizations who are trying to provide care for all who need it during a crisis but could potentially have the patient unattributed to them. While expanding the definition of primary care services in order to determine beneficiary assignment is a step in the right direction, we still take the stance that **the agency should consider analyzing data from both 2019 and 2020 in determining 2021 attribution**. A two-year look back period would offer a solution for organizations operating under both retrospective and prospective attribution, accounting for the potential disruption to both.

We welcome the clarification from the agency that the extreme and uncontrollable circumstances policy will apply through the duration of the PHE, including any extensions, which offers MSSPs protection against shared losses during this time period. While it now appears that the PHE will be extended through October, uncertainty remains for the months following. **We request that CMS implement the MSSP extreme and uncontrollable circumstance policy will continue for through November and December 2020.**

Payment for Audio-Only Telephone Evaluation and Management Services

CMS finalized new RVUs for audio-only telephone evaluation and management (E/M) services based on the RVUs associated with the level 2-4 established office/outpatient E/M visits. CMS also crosswalked the direct PE inputs associated with these codes. The telephone E/M services were added to the list of Medicare telehealth services for the duration of the PHE and CMS separately issued a Section 1135 waiver for these services.

APG strongly supports the implementation of reimbursement parity for telehealth services that would have otherwise been conducted face-to-face. By recognizing the same flexibilities for audio-only services, CMS provides much needed relief for providers – including many rural and other underserved providers and patients – who are unable to utilize audio/video telehealth services, but are attempting to follow other Administration guidelines to limit the number of patients and providers within their facilities to lessen the spread of COVID-19. **APG also strongly recommends CMS continue this reimbursement parity after the PHE, recognizing the increased access to care that telehealth facilitates, including audio-only services, offer to patients.** This will help ensure providers are able to continue offering these services facilitated by a steady and adequate funding stream. Without these funding streams, services provided via these modalities may be unsustainable. While APG understands common sense parity is required and that not all audio-only services equal that of an in-patient visit, ensuring the services – such as initial visit follow-ups and treatment adjustment visits – can be delivered via an audio-only medium allows providers to offer audio-only services sustainably. Implementation of the recommendation to extend this payment parity beyond the end of the PHE could be accomplished by CMS further revising the definition of an “interactive telecommunications system” within the interim final rule to include systems that provide audio-only communication.

Time Used for Level Selection for Office/Outpatient Evaluation and Management Services Furnished Via Medicare Telehealth

CMS finalized, on an interim basis, that the typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor. On an interim basis office/outpatient E/M level selection when furnished via telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. Any requirements regarding documentation of history and/or physical exam in the medical record have been removed.

APG applauds CMS' removal of documentation requirements under this section. These requirements represented an additional administrative burden on physicians during a time where their attention is already spread thin and would be best spent serving patients during a public health emergency. **We also commend the agency for listening to healthcare providers regarding MDM times not aligning with the typical times included in the office/outpatient E/M code descriptors and subsequently changing its policy.** Aligning the two processes will allow for a more accurate accounting of E/M services for telehealth and strengthen the use of these services during the PHE.

Conclusion

Thank you for your attention to the above comments. Again, we reiterate our robust support for the extensive changes offered by CMS throughout the course of this public health emergency. It is important that CMS continues to work with stakeholders at this time. Please feel free to contact Valinda Rutledge, Senior Vice President, Federal Affairs, (vrutledge@apg.org) if you have any questions or if America's Physician Groups can provide any assistance as you consider these issues.

Sincerely,



Donald H. Crane
President and CEO
America's Physician Groups