



June 1, 2020

Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), the largest medical specialty organization and the second largest physician group in the United States, thank you for the opportunity to provide comments on the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE) interim final rule (IFR). I write to express the College's sincere appreciation for everything the Centers for Medicare and Medicaid Services (CMS) has done to combat COVID-19 and improve the lives of the millions of beneficiaries served by Medicare and Medicaid. These changes have greatly assisted physicians and other clinicians on the frontlines of this pandemic. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students dedicated to scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Below, we have summarized our comments and recommendations. We hope that our comments will assist CMS in responding to the current healthcare crisis before the country. We sincerely appreciate the open dialogue with the agency about our concerns. Our conversations have been instrumental in promoting changes that provide flexibility for clinicians to combat the COVID-19 pandemic, support physicians in their ability to deliver innovative care, and protect the integrity of the Medicare trust funds. We appreciate this opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that promote the health and safety of patients during this public health emergency (PHE).

### **Fee-for-Service Policy Changes**

#### **Telephone Calls**

**CMS Policy:** On April 6<sup>th</sup>, CMS published an interim final rule making certain changes to payment policies governing telehealth. In that interim final rule, CMS finalized policies to provide reimbursement for CPT codes 99441 – 99443, which are *telephone evaluation and management services provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*. CMS noted that these services would be available to new and established patients, and that CMS would not audit to determine whether a prior relationship existed.

**ACP Comments:** The College strongly supports CMS' decision to provide reimbursement for CPT codes 99441 – 99443. This decision by the agency offers an important new option for patients who are at serious risk from COVID-19 complications. It also provides an additional resource for physicians that need to conduct a longer conversation of up to 30 minutes if necessary and also would not require that the discussion be patient-initiated unlike other available codes. Additionally, while over 90% of seniors currently report having cellphones, less than 40% of those phones are smartphones —making it much more challenging for this

vulnerable population to be able to utilize more robust traditional telehealth visits that require two-way audio and video service or even e-visits that utilize a patient portal from their home. For these patients, providing coverage and payment for telephone consultations that do not require smartphone capabilities is an essential change. **We strongly encourage CMS to remove the requirement that these visits not originate from a related E/M visit within the past 7 days or lead to an E/M visit/procedure within the next 24 hours. It is critically important that CMS work to remove barriers that may prevent patients from accessing the care they need. It is possible that patients may need follow-up visits. Additionally, this language in the code descriptor may inadvertently preclude patients from accessing care and may force high-risk groups to use in-person visits when their health status may suggest a telephone visit, instead. Finally, we recommend that CMS allow clinicians to use medical decision-making (MDM) or time when billing for telephone E/M visits to mirror the flexibilities allowed when billing telehealth E/M codes. It is important that clinicians have similar rules and guidelines to minimize administrative complexity and maximize their time focused on delivering patient care. ACP looks forward to working with CMS to address this important issue.**

### Telehealth

**CMS Policy:** The IFR specified that CMS would not change the definition of telehealth (interactive telecommunications systems) services. However, CMS did finalize a temporary exception for the duration of the PHE that carves out space for digital apps such as FaceTime, Skype, and others. CMS also finalized a number of other changes to telehealth services, including:

- Allowing physicians and clinicians who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person, albeit for the current PHE;
- Approving the use of the CPT Telehealth modifier 95 to be applied to claim lines that describe services furnished via telehealth. This change will permit CMS to make appropriate payment for services furnished via Medicare telehealth, which would have been furnished in person, at the same rate they would have been paid if the services were furnished in person;
- Temporarily adding a number of services to the list of telehealth services for the duration of the PHE
- Removing frequency limitations for subsequent inpatient visits and subsequent nursing facility visits furnished via Medicare telehealth; and
- Exercising enforcement discretion and waiving penalties for HIPAA violations against health care clinicians that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype. There will be no penalties for waiving/reducing cost-sharing for non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

**ACP Comments:** ACP welcomes these policy changes by CMS. These changes are critical to ensuring greater access to medical services for patients while limiting the risk of infection. Taken together, these rule changes also represent critical efforts to support physician practices during this crisis. Now more than ever, physicians require flexibility in order to meet patients where they are. Our members greatly appreciate the efforts by CMS to provide flexibility during these uncertain and unprecedented times. **We encourage CMS to maintain these modifications after the PHE ends and will be providing additional feedback and recommendations along these lines in the coming days. We look forward to additional discussions about how to enhance these flexibilities.**

### Level Selection for Office/Outpatient E/M Visits When Furnished via Medicare Telehealth

**CMS Policy:** CMS announced in the IFR that when selecting the appropriate code level for office/outpatient E/M level visits furnished via telehealth, clinicians can use medical decision-making (MDM) or time. The agency is maintaining the current definition of MDM for the duration of the PHE. CMS notes that time is defined as all

of the time associated with the E/M visit on the day of the encounter. Additionally, CMS temporarily removed any requirements regarding documentation of history and/or physical exam in the medical record.

**ACP Comments:** ACP strongly supports these policies finalized by CMS to grant additional relief and flexibility for physicians and patients during the midst of the PHE. This change will allow documentation requirements for telehealth E/M services to mirror those of E/M visits furnished in-person that are scheduled to go into effect in 2021. As the College mentioned in our comments to the agency supporting the E/M documentation changes, in this case we continue to believe these policies will improve patients' access to care by enabling doctors to spend more time with their patients and less time on unnecessary documentation. The College welcomes these changes to telehealth E/M documentation requirements and believes that they will be essential to enhancing care delivery by improving care outcomes, increasing longevity, lowering costs, and reducing preventable hospital and emergency room admissions while allowing patients to maintain their safety. We look forward to working with CMS to ensure that these finalized policies work in sync with E/M changes scheduled to go into effect in 2021.

### **Direct Supervision**

**CMS Policy:** The proposed rule noted that in instances where direct supervision is required by physicians and at teaching hospitals, CMS will allow supervision to be provided using real-time interactive audio and video technology. The College welcomes this decision by the agency to allow attending physicians and residents/fellows the ability to communicate over interactive systems by waiving the in-person supervision requirement.

**ACP Comments:** This is an important step that promotes efficient patient care and allows physicians and supervisees to work together while abiding by important social distancing restrictions. We are fully supportive of this change that will further promote patient care. **We encourage CMS to maintain these modifications after the PHE ends and until supervising physicians feel comfortable they are able to control the spread of infection rates within their facilities and practices. The College remains ready and willing to work with CMS on these changes to ensure that they work in sync with the additional historic actions taken to date.**

### **Home Health**

**CMS Policy:** The IFR made changes to rules that will allow an individual to be considered to be "confined to home" (homebound) for the purposes of home health benefits eligibility if they have been diagnosed with, are presumed to have COVID-19, or if it is medically contraindicated for the patient to leave their home. CMS clarified that the agency is amending these regulations on an interim basis to provide home health agencies (HHAs) with flexibility, in addition to remote patient monitoring, to use various types of telecommunications systems in conjunction with the provision of in-person visits.

**ACP Comments:** These changes to the HHA regulations will allow additional beneficiaries to gain access to critically important home health services. These services are an important benefit for many and ACP is pleased to see that CMS is loosening restrictions at a time when many could benefit from the rules change. **We encourage CMS to ensure that all relevant entities and authorities charged with executing home health regulations are promptly and appropriately notified of this change to ensure that all beneficiaries eligible for this new service can enroll. Additionally, ACP recommends that CMS maintain these modifications after the PHE ends and until clinicians feel comfortable they are able to control the spread of infection rates.**

### **Hospice**

**CMS Policy:** CMS is amending the hospice regulations on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patient's terminal illness and related conditions without

jeopardizing the patient's health or the health of those who are providing such services during the PHE for the COVID-19 pandemic.

**ACP Comments:** ACP welcomes the decision by CMS to make it easier for beneficiaries to receive hospice services. At such a critical moment in their lives, it is imperative to do everything possible to make lives easier and maintain patient, clinician, and caregiver safety. The expansion of services to include telehealth is a welcome change and one that will hopefully grant additional flexibility to clinicians to meet the needs of their patients where they are. **We encourage CMS to maintain these modifications after the PHE ends and until clinicians feel comfortable they are able to control the spread of infection rates.**

### **Rural Health Centers & FQHCs**

**CMS policy:** CMS expanded the services that can be included in the payment for HCPCS code G0071 (*Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only*) to include e-visit codes. In the IFR, the agency also revised the payment rate for HCPCS code G0071 to include the national non-facility payment rates for these three new codes. Effective for services furnished on or after March 1, 2020 and throughout the PHE for the COVID pandemic, CMS notes that the payment rate for HCPCS code G0071 will be the average of the PFS national non-facility payment rate for HCPCS code G2012 (communication technology-based services), HCPCS code G2010 (remote evaluation services), and online digital evaluation and management services (CPT codes 99421-23). At the same time, CMS is lifting the face-to-face requirements for these services during the PHE. Finally, CMS ruled that all virtual communication services that are billable using HCPCS code G0071 will also be available to new patients that have not been seen in the RHC or FQHC within the previous 12 months.

**ACP Comments:** The College welcomes these rule changes by CMS. The COVID-19 pandemic has drastically changed the way physicians are able to care for their patients. At this critical juncture, we are very pleased that CMS recognizes the need to modify current practices in RHC's and FQHC's by giving them additional flexibility to meet patients' needs. These changes will allow patients to continue to have access to care in the midst of a pandemic. We look forward to working with CMS to discuss the role of these changes in beyond the PHE.

### **Remote Patient Monitoring Codes**

**CMS Policy:** In the IFR, CMS finalized policy that now allows remote patient monitoring (RPM) to be used for both new and established patients. The agency also notes that consent to receive RPM services can be obtained once annually, including at the time services are furnished for the duration of the PHE for the COVID-19 pandemic. CMS will also allow RPM codes to be used for both acute and chronic conditions.

Currently, CMS provides payment for seven CPT codes in the RPM code family: **99091** (*Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time*); **99453** (*Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*); **99454** (*Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*); **99457** (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*); **99458** (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes*); **99473** (*Self-measured blood pressure using a device validated for clinical accuracy*);

*patient education/training and device calibration); and 99474 (Separate self-measurements of two readings one minute apart, twice daily over a 30- day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient).*

**ACP Comments:** The College applauds the agency's decision to expand access to RPM codes by allowing physicians to bill them for both new and established patients. We also welcome the burden reduction attained by allowing patients to consent to these services once annually. Additionally, the decision by the agency to allow these codes to be used for both acute and chronic conditions further expands access to these services at this important time when patients and their care teams need additional resources to meet the challenges they are facing. These changes will help to relieve physician burden and allow physicians more time to treat complex patient issues that require more than remote monitoring. **We encourage CMS to maintain these modifications after the PHE ends and until supervising physicians feel comfortable they are able to control the spread of infection rates.**

### **Quality Payment Program (QPP)**

#### **Merit-based Incentive Payment System (MIPS) MIPS Extreme and Uncontrollable Circumstances Hardship Exceptions**

**CMS policy:** CMS extended the 2019 MIPS reporting deadline to April 30, 2020. Clinicians who do not submit data by this date will automatically qualify for an extreme and uncontrollable circumstances hardship exception, have all categories reweighted to zero, and receive a neutral payment adjustment. Clinicians who have submitted data also have the opportunity to apply for an extreme and uncontrollable circumstances hardship exception, the deadline for which was extended to April 30, 2020 for COVID-19 related applications only. For these applications, hardship exception applications will supersede any data received and reweighting will occur. This policy will not apply to MIPS eligible clinicians subject to the APM scoring standard, including those participating in the Medicare Shared Savings Program (MSSP). CMS clarifies that for MIPS Alternative Payment Models (APMs), the APM Entity will be scored and receive a payment adjustment unless all assigned clinicians and groups either do not submit any data, or submit hardship exception applications for the Promoting Interoperability and Quality Categories. CMS broadened the MSSP extreme and uncontrollable circumstances policy to disasters that occur during the quality reporting period if the reporting period is extended.

**ACP comments:** ACP appreciates CMS instituting a national hardship exception for the 2019 performance year for the COVID PHE that would be automatically applied in cases where no data is received. This broad-ranging approach is exactly the kind of support clinicians need as they focus on treating patients and stopping the spread of this virus. However, times of crisis like this are chaotic, making it difficult, particularly for large, multi-specialty groups and MIPS APM Entities, to ensure that every single clinician or group under their TIN either does not submit any data (including inadvertently through a vendor) or proactively submit a hardship exception. The last thing clinicians should be worrying about is whether or not they remembered to submit an application for an exception that is broadly available. **ACP strongly urge CMS to institute an automatic exception that would apply to all clinicians, including if data is submitted. In these cases, clinicians would receive the better of the two scores; the neutral payment adjustment or the score based on the data submitted, similar to how CMS applies the most advantageous score in facility-based scoring. We believe this approach would minimize administrative burden, encourage reporting of data, and reverse the disadvantage to MIPS APMs.**

#### **New Improvement Activity for Participating in COVID-19 Clinical Trials**

**CMS policy:** CMS added a new improvement activity (IA) for the CY 2020 performance period related to the COVID-19 PHE. This IA (IA\_ERP\_XX) promotes clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection. To receive credit, clinicians must report their findings through an open source clinical data repository or registry.

**ACP comment:** ACP strongly supports adding new IAs that recognize the work clinicians are doing to combat COVID-19, including participating in clinical trials. Encouraging clinicians to participate in these sorts of activities are critical to containing and defeating the crisis. **ACP recommends, all COVID-19 related IAs automatically qualify for full credit for the IA category to maximize incentive for participating in these activities at this critical time. At a minimum, all COVID-19-related IAs should be high-weighted.**

### Innovation Center Model Flexibilities

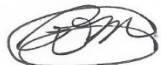
**CMS policy:** For the Medicare Diabetes Prevention Program (MDPP), CMS will permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime to allow beneficiaries to remain eligible for MDPP services despite a temporary break in service, attendance, or weight loss achievement. CMS will also waive the limit on the number of virtual make-up sessions and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis or suspend in-person services and resume services at a later date, both within certain parameters. For the Comprehensive Care for Joint Replacement (CJR) Model, CMS extended the length of Performance Year Five by three months and broadened the extreme and uncontrollable circumstances policy to account for all participant hospitals affected by the COVID-19 pandemic. The Agency also capped actual episode payments at the target price for episodes with an anchor hospitalization that occurs during the PHE or up to 30 days prior.

**ACP comment:** ACP appreciates and supports the flexibilities afforded under the MDPP and CJR models, particularly the capping of the actual price at the target price for episodes that occur during the PHE. Flexibilities like this are exactly the type of support and assurance clinicians need to continue participating in APMs, particularly those that are risk bearing. ACP also appreciates CMS' comments in the IFR that it "recognizes current regulations may be insufficient and additional actions may be necessary ... [and] will consider additional rulemaking to amend or suspend APM QPP policies as necessary in light of the public health emergency due to COVID-19." **We strongly urge the Agency to establish similar flexibilities and assurances for APMs more broadly so that we do not see a mass exodus from APMs and lose the important progress that has been made toward value-based reimbursement. Specifically- CMS should apply the same target price capping strategy to all episode-based payment models. For the MSSP and other population-based payment models based on a historical benchmark, CMS should similarly cap spending at the historical benchmark.** At a minimum, CMS should offer participants the option to mitigate downside risk in exchange for reduced upside risk. Opportunities for up front financial support would help to sustain participation in all APMs during this difficult time, particularly for small, rural, and independent practices with less financial reserves.

### **In Conclusion**

ACP is appreciative and encouraged by the actions taken by CMS to date that will be enormously beneficial to physicians and their teams in both caring for patients impacted by this pandemic and for patients at-large. We look forward to working with you to understand whether all or some of these changes should be maintained after the PHE ends. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or email at [boutland@acponline.org](mailto:boutland@acponline.org) if you have questions or need additional information.

Sincerely,



Ryan D. Mire, MD, FACP  
Chair, ACP Medical Practice and Quality Committee