



May 31, 2020

Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1744-IFC and CMS-5531-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: AAFP's Response to COVID-19 Policy Changes (CMS-1744-IFC and CMS-5531-IFC)

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 136,700 family physicians and medical students across the country, I write in response to the two interim final rules with comment period, one titled, "Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" as [published](#) by the Centers for Medicare & Medicaid Services (CMS) in the April 6, 2020 *Federal Register* and the other titled "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" as [published](#) in the May 8, 2020 *Federal Register*.

The AAFP very much appreciates that CMS is temporarily relaxing several regulations to help the healthcare system deal with COVID-19 and expected patient surges and that these changes are retroactively applicable to March 1, 2020. These actions include efforts to promote telehealth in Medicare, reduce administrative burden, expand the healthcare workforce, and increase hospital capacity. While we profoundly appreciate the barriers being removed expediently to render care accessible during the public health emergency (PHE) period to achieve the many critical aims, we also look forward to working with the agency further to support the appropriate expansion of telehealth and access to care with a patient's family physician and usual source of care following the PHE period.

### Payment for Medicare Telehealth Services

#### Summary

Previously, CMS required physicians to report telehealth services with place of service (POS) code 02 (Telehealth) and automatically paid for services at the facility rate under the Medicare physician fee schedule. CMS now instructs physicians who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. CMS further instructs physicians to append modifier 95 (Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System) to the line-item on the claim to indicate the service was provided via telehealth. CMS will make payment at either the non-facility or facility rate under the Medicare physician fee schedule, depending on the POS code used.

---

## **STRONG MEDICINE FOR AMERICA**

### President

Gary LeRoy, MD  
Dayton, OH

### President-elect

Ada Stewart, MD  
Columbia, SC

### Board Chair

John Cullen, MD  
Valdez, AK

### Directors

Sterling Ransone, MD, *Deltaville, VA*  
Windel Stracener, MD, *Richmond, IN*  
Erica Swegler MD, *Austin, TX*  
James Elzy, MD, *Washington, DC*  
Dennis Gingrich, MD, *Hershey, PA*  
Tochi Iroku-Malize, MD, *Bay Shore, NY*

Andrew Carroll, MD, *Chandler, AZ*  
Steven Furr, MD, *Jackson, AL*  
Margot Savoy, MD, *Media, PA*

Brent Sugimoto, MD (New Physician Member), *Richmond, CA*  
Kelly Thibert, DO, MPH (Resident Member), *Columbus, OH*  
Margaret Miller (Student Member), *Johnson City, TN*

### Speaker

Alan Schwartzstein, MD  
Oregon, WI

### Vice Speaker

Russell Kohl, MD  
Stilwell, KS

### Executive Vice President

Douglas E. Henley, MD  
Leawood, KS

In addition, for the duration of the PHE CMS is adding approximately 80 services to the list of Medicare-covered telehealth services. The complete list can be found on the CMS website.

#### *AAFP Response*

The AAFP supports these needed changes in the context of the PHE. We hope to work further with the agency to identify telehealth codes that should permanently be handled in this manner. Many physicians have quickly deployed new or updated existing capabilities in order to deliver telehealth services. Given these investments, an automatic return to pre-COVID telehealth policies would be a setback for physicians and patients' access to care.

#### Telehealth Modalities and Cost-sharing

##### *Summary*

Under this new regulation, CMS states that interactive communications system means any multimedia communications that include, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. This exception is effective for the duration of the COVID-19 pandemic.

CMS clarifies that the Office of Inspector General's (OIG) policy, stating that physicians will not be subject to sanctions for reducing or waiving cost-sharing obligations, applies to a broad category of non-face-to-face services, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

#### *AAFP Response*

The AAFP fully agrees with the clarification on "phone" being a viable interactive telecommunications system. We also believe that there is tremendous value in asynchronous telecommunication systems and ask CMS to reimburse for the use of those delivery methods as well during the PHE.

We support the OIGs waiving any resulting administrative sanctions for reducing or eliminating any cost-sharing obligations for Federal health care program beneficiaries for telehealth services. Such reductions or eliminations should be at the discretion of the physician or practice.

Many of our members have inquired about whether to charge co-pays and deductibles to their patients. The AAFP has advised them that the *Families First Coronavirus Response Act* (FFCRA) waives cost sharing for COVID-19 testing-related services for Medicare Part B patients. Cost-sharing is waived for office visits that result in the order or administration of the COVID-19 test, or the evaluation of an individual to determine the need for such a test. The cost-sharing waiver is effective for dates of service starting March 18, 2020, until the end of the current PHE.

#### Communication Technology-Based Services (CTBS)

##### *Summary*

On an interim basis, CMS is finalizing that HCPCS G2012 and G2010 can be provided to both new and established patients. CMS is also finalizing on an interim basis that consent may be obtained at the same time a service is furnished. Consent may be obtained by auxiliary staff under general supervision, as well as the billing practitioner. In addition, CMS will exercise enforcement discretion as it pertains to the restriction that CPT 99421-99423 must be provided to established patients. CMS will not conduct reviews to consider whether the services were provided to established patients.

CMS is broadening the availability of HCPCS G2012 and G2010 to allow other practitioners to furnish the services. This includes licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists. CMS notes this is not an exhaustive list and seeks input on other types of practitioners who might be providing these services in the context of the COVID-19 pandemic.

CMS is designating HCPCS G2010, G2012, G2061, G2062, G2063 as CTBS “sometimes therapy” services that would require private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN modifier on claims for these services.

#### *AAFP Response*

The AAFP appreciates and supports CMS’s decision, on an interim basis, to allow physicians and designated non-physician practitioners to receive Medicare payment for these services when provided to new and established patients. We also appreciate and support CMS’s decision to permit consent at the time a service is furnished and to allow auxiliary staff under general supervision to obtain that consent.

The decision to allow auxiliary staff under general supervision to obtain consent for these services does raise questions about the extent to which ancillary clinical staff such as registered nurses, licensed practical nurses, and medical assistants may be involved in the services in question and still have those services billed under the physician’s provider number as “incident to” services. For instance, could a physician delegate a virtual check-in to a nurse care manager within the practice and report the service as G2012 under the physician’s provider number if all the necessary “incident to” requirements are met?

Ancillary staff in a family medicine practice often handle much of the virtual communication between physicians and patients as part of an established plan of care (e.g. conveying symptoms and history to the physician, communicating physician recommendations and instructions back to the patient along with signs/symptoms to watch for that would indicate a change in clinical course and need for re-evaluation and/or in-person care per the physician’s instructions). Where this staff time is not otherwise counted towards other services (e.g. chronic care management), it may be helpful to report communication technology-based services as “incident to” services under the physician’s provider number. Further sub-regulatory guidance from CMS on this point would be helpful.

#### Direct Supervision by Interactive Telecommunications Technology

##### *Summary*

For the duration of the COVID-19 pandemic, CMS is revising the definition direct supervision to allow direct supervision to be provided using real-time interactive audio and video technology. CMS is seeking information as to whether there should be any guardrails and what kind of risk this policy might introduce for beneficiaries while reducing the risk of COVID-19 spread. CMS notes the revision only pertains to the way the supervision requirement can be met. It does not change the underlying payment or coverage policies related to the scope of Medicare benefits, including Part B drugs.

CMS is also altering the definition of direct supervision at §410.32(b)(3)(ii) to state that necessary presence of the physician for direct supervision includes virtual presence through

audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.

#### *AAFP Response*

The AAFP supports these relaxations in direct supervision and would encourage CMS to continue this policy permanently. This change will improve patients' access to care by allowing the resident and teaching physician to be in separate locations.

#### Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

##### *Summary*

CMS is expanding the services that can be included in the payment for HCPCS G0071. CMS will update the payment rate to reflect the addition of these services. Specifically, CMS is adding CPT codes:

- 99421 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes),
- 99422 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes), and
- 99423 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes).

The payment rate for G0071 will be the average of the national non-facility payment rates of HCPCS G2012 and G2010 and CPT 99421-99423. The RHC and FQHC face-to-face requirements are waived for these services. These changes are effective for services furnished on or after March 1, 2020, and throughout the duration of the COVID-19 pandemic.

CMS is finalizing the virtual communication services that are billable using HCPCS G0071 will be available to new patients that have not been seen in the RHC or FQHC within the previous 12 months. Where obtaining prior beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, CMS will allow consent to be obtained when the services are furnished. Consent must be obtained before the services are billed. Consent may be obtained by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication service and monthly care management codes. These provisions are effective for the duration of the COVID-19 pandemic.

#### *AAFP Response*

The AAFP fully supports expanding payment to RHCs and FQHCs as finalized.

#### Application of Teaching Physician and Moonlighting Regulations During the PHE

##### *Summary*

Under usual rules, Medicare payment is made for services by a teaching physician involving residents *only* if the physician is physically present for the service or procedure.

During the COVID-19 pandemic and in order to allow teaching hospitals to maximize their workforce and minimize provider exposure to the virus, CMS is relaxing this requirement to allow teaching physicians to provide services with medical residents virtually through audio/video real-time communications technology. In other words, the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service.

This does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

Furthermore, during this pandemic, CMS will allow all levels of an office/outpatient E/M service provided in primary care centers to be provided under direct supervision of the teaching physician by interactive telecommunications technology. The use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means while the resident is furnishing services via telecommunications technology, and thus, would meet the requirement for teaching physician presence for office/outpatient E/M services furnished in primary care centers. This includes situations when the resident is furnishing these services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology.

Teaching physicians may continue to exercise their clinical judgment to decide whether it is appropriate to utilize these flexibilities in furnishing their services involving residents.

CMS seeks comments on the appropriateness of direct supervision by interactive telecommunications technology, with consideration of balance of risk that might be introduced for beneficiaries with reducing exposure risk and the increased spread of the disease.

For licensed resident physicians, CMS is temporarily allowing separately billable “moonlighting” physicians’ services performed in the inpatient setting of a hospital in which they have their training program, provided that the services meet the conditions of payment for physicians’ services to beneficiaries, the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed, and the services are not performed as part of the approved GME program.

#### *AAFP Response*

The AAFP appreciates and supports the decision to allow attending physicians and residents/fellows the ability to communicate over interactive systems by waiving the in-person supervision requirement. We agree this will better allow the healthcare workforce to treat patients.

We also appreciate that CMS, via CMS–5531–IFC, allows the teaching physician to meet the requirement to review the service with the resident, during or immediately after the visit, through virtual or remote means via interactive audio/video real-time communications technology. Doing so would enable the attending physician and residents/fellows to discuss cases at the end of the day to ensure that proper care and guidelines are strenuously followed.

#### Remote Physiologic Monitoring

##### *Summary*

CMS reimburses seven CPT codes in the Remote Physiologic Monitoring (RPM) code family. RPM services are communication technology-based services and, as such, would be billable only for established patients.

Recognizing that allowing RPM services to be furnished only to established patients is an obstacle to delivery of reasonable and necessary care, CMS is temporarily allowing RPM services to be furnished to new patients, as well as to established patients.

CMS previously required verbal consent from a Medicare beneficiary to receive the RPM services and the agency continues to believe that patient consent is important. During the pandemic, CMS will allow consent to receive RPM services can be obtained once annually, including at the time services are furnished. However, CMS suggests the physician or other health care practitioner review consent information with a beneficiary, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained.

CMS is also clarifying that RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions. The typical patient needing RPM services may have a chronic condition. However, RPM can be used for other conditions. For example, RPM services allow a patient with an acute respiratory virus to monitor pulse and oxygen saturation levels using pulse oximetry.

In response to stakeholder concerns, CMS is establishing a policy to allow RPM monitoring services reported to Medicare for periods that are fewer than 16 of 30 days, but no less than two days, as long as the other requirements are met. This policy is only effective for the duration of the COVID-19 PHE and limited to patients with a suspected or confirmed diagnosis of COVID-19.

#### *AAFP Response*

The AAFP supports these changes and appreciates CMS addressing the RPM code family in this regulation. During the PHE, we support payment of the RPM codes for new patients as well.

#### Telephone Evaluation and Management (E/M) Services

##### *Summary*

In recognition of the difficulties some beneficiaries face in acquiring or utilizing audio-video technology, CMS is finalizing separate payment for telephone E/M services (CPT codes 98966-98968 and CPT codes 99441-99443). CMS is crosswalking payment for 99441-99442 to 99212-99214, respectively. While the code descriptors refer to established patients, CMS is extending these services to new and established patients and will not conduct reviews to consider whether the services were provided to established patients. CPT codes 98966-98968 refer to services performed by practitioners who cannot separately bill for E/M services.

#### *AAFP Response*

The AAFP is appreciative that CMS took the bold step during the PHE to cover and pay for 99441-99443 and to pay for them at a rate on par with established patient office visits of comparable length. This action by CMS supports what we hear from our physicians. Namely, during this crisis, they have been able to conduct successful audio-only telephone visits with patients, in lieu of in-person or telehealth visits, obtaining much the same information and providing comparable care that they would using audio and video capable equipment.

The AAFP encourages CMS to include 99441-99443 in the list of services that count toward HCC scores. HCC scores are playing an increasingly important role in value-based payment programs. Many CMMI models, including Comprehensive Primary Care Plus and Primary Care First, use HCC to risk-adjust population-based payments meant to support innovation in care delivery. Due to the COVID-19 pandemic, it is clear that rapid adoption of alternative visit types that are appropriately reimbursed are critical to ensuring adequate access for patients, sustained health of communities, and viability for primary care practices. Audio-only encounters have been vital during the PHE, especially for the Medicare population. Excluding diagnoses

captured during these visits may decrease HCC scores. Basing population-based payments on inaccurate HCC scores will negatively impact practices in APMs, including PCF, by providing inadequate payment to support their patients. We urge CMS to address this issue to ensure the value-based payment movement does not lose momentum during the PHE.

### Change to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy

#### *Summary*

In response to the COVID-19 pandemic, CMS is providing Accountable Care Organizations (ACOs) an additional month to submit some quality data, but CMS recognizes that may cause problems given how the current extreme and uncontrollable circumstances policy is set up for ACOs that count as APMs. CMS is removing the restriction that prevents the ACO's extreme and uncontrollable circumstances policy from applying to disasters that occur during the quality reporting period if the reporting period is extended. CMS is also reducing the amount of an ACO's shared losses in 2020 to account for the COVID-19 pandemic.

CMS is forgoing the application cycle for a January 1, 2021 start date. ACOs that entered a first or second agreement period with a start date of January 1, 2020, may elect to extend their agreement period for a fourth performance year. The fourth performance year would run from January 1, 2021, to December 31, 2021. ACOs who extend their agreement will be able to remain under their existing historical benchmark for an additional year. Extending the agreement is voluntary. ACOs that do not choose to extend their agreement period will conclude their participation in the program at the expiration of their current agreement period, December 31, 2020.

CMS is allowing ACOs participating in the BASIC track glide path to maintain their current level under the BASIC track for PY 2021. ACOs that select the advancement deferral option will be automatically advanced to the level of the BASIC track's glide path it would have participated in during PY 2022 if it had automatically advanced in 2021.

CMS is clarifying that the months affected by the extreme and uncontrollable circumstance will begin with January 2020, and continue through the end of the PHE, including any subsequent renewals. If the COVID-19 PHE extends for the entirety of CY 2020, all shared losses for PY 2020 will be mitigated for all ACOs participating in performance-based risk tracks. The current PHE has covered four months, meaning shared losses incurred in PY 2020 will be reduced by at least one-third.

CMS is revising its policy and will exclude from Shared Savings Calculations all Parts A and B FFS payment amounts for an episode of care for treatment of COVID-19, triggered by an inpatient service, as specified on Parts A and B claims dates of service during the episode. CMS does not believe treatment for COVID-19 that does not result in an inpatient admission raises the same level of concern in terms of generating unexpected performance year expenditures that would not be appropriately reflected in benchmark calculations.

Many of the services delivered via telehealth are reported using codes that describe "face-to-face" services. As such, most primary care services on the approved telehealth services list are already included in the definition of primary care services for the purposes of the SSP assignment methodology. However, codes for virtual services are not currently included in the definition of primary care services for the SSP assignment methodology. CMS is revising the

definition of primary care services used in the SSP assignment methodology for the 2020 performance year and any subsequent performance year that starts during the PHE to include: HCPCS codes G2010 and G2012, CPT codes 99421-99423, and CPT codes 99441-99443. E-visit HCPCS codes G2061-G2063 and telephone E/M CPT codes 99441-99443 are not included in the definition of primary care services used for assignment as these codes are not furnished by ACO professionals.

#### *AAFP Response*

We are appreciative that the IFCs enact the MSSP extreme and uncontrollable circumstances policy. We urge CMS to reconsider forgoing a 2021 application cycle. An alternative would be to extend the application deadlines instead of forgoing the cycle altogether.

The AAFP supports CMS' policy to allow ACOs to extend their current agreement for an additional performance year. We also support allowing ACOs in the BASIC track to remain in their current level for the 2021 performance year. However, we are extremely concerned with CMS' policy to advance the ACO to the level it would have participated in 2022 had it not maintained its 2020 level for the 2021 performance year. ACOs are still in the midst of dealing with the COVID pandemic and a second wave, which may be worse than the first, is still possible. ACOs will be dealing with the effects of the PHE long after the PHE has ended. The full financial impact of COVID-19 will not be known for several years. Assuming an ACO will be prepared to assume downside risk for the first time or assume increased financial risk in 2022 is premature. It is vital that we allow ACOs to remain focused on caring for patients and give them the time to recover financially. Long term viability of ACOs is paramount to access and continuity of care, especially for patients with complex chronic conditions who are at increased risk of contracting COVID-19.

We appreciate the steps CMS is taking to protect ACOs from potential losses. We ask that CMS offer ACOs the option of full protection from losses in exchange for a reduced shared savings rate, no less than 40 percent. The uncertainties associated with the pandemic has made ACOs wary of continuing their participation in the program. To ensure the shift to value-based payment is not hindered, we encourage CMS to offer additional flexibilities. We also ask CMS to extend the deadline for ACOs to exit the program and avoid financial losses to at least October 31, 2020. Without additional time, ACOs may exit the program prematurely.

The AAFP supports CMS' policy to remove expenditures associated with COVID-19 from the benchmarking methodology. We urge CMS to exclude costs for outpatient services associated with a COVID-19 diagnosis, regardless of whether the patient has an inpatient hospital admission. The long-term effects of COVID-19 are unknown. Patients may need ongoing care as they recover, and this care may not be provided in the inpatient setting. We ask that CMS monitor the long-term costs of outpatient care for recovered COVID-19 patients before including these costs in future benchmarking methodologies as to fully assess the total cost of care implications of the disease.

Additionally, patients are postponing or forgoing immunizations, preventive, and chronic care. The lack of or delay of care may result in preventable illnesses or exacerbate chronic conditions, causing worse health outcomes and increased utilization. We ask CMS to ensure these issues are addressed for the current performance year and in future policymaking.

### Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth *Summary*

On an interim basis, CMS is revising its policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on medical decision making (MDM) or time and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is like the policy that will apply to all office/outpatient E/M services beginning in 2021 under policies finalized in the calendar year 2020 Medicare physician fee schedule final rule.

CMS is maintaining the current definition of MDM and defining time as all the time associated with the E/M on the day of the encounter. CMS notes that currently there are typical times associated with the office/outpatient E/M services. CMS is finalizing those times as what should be met for purposes of level selection.

This policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for the COVID-19 pandemic.

#### *AAFP Response*

In general, the AAFP endorses this change. It allows physicians a chance to become accustomed to the new rules before they apply to all office visits, whether telehealth or not, in 2021.

In CMS–5531–IFC, CMS addressed a concern raised by the physician community, and the AAFP appreciates this step. The March 31<sup>st</sup> COVID–19 IFC relies on typical times listed in the agency’s public use file even when those times do not align with the typical times included in the office/outpatient E/M code descriptors. CMS agreed that discrepancies between times can be confusing, and because the times are being used for the purpose of choosing which level of office/ outpatient E/M CPT code to bill, the times listed in the codes themselves would be most appropriate for the purpose. Therefore, CMS is finalizing on an interim basis, for the duration of the PHE for the COVID–19 pandemic, that the typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor.

### Counting of Resident Time During the PHE for the COVID-19 Pandemic *Summary*

Current Medicare requirements have specific rules on when a hospital may count a resident for purposes of Medicare direct graduate medical education (DGME) payments or indirect medical education (IME) payments. Currently, if the resident is performing activities with the scope of his/her approved program in his/her own home, or a patient’s home, the hospital may not count the resident. A hospital that is paying the resident’s salary and fringe benefits for the time that the resident is at home or in a patient’s home, but performing duties within the scope of the approved residency program and meets appropriate physician supervision requirements can claim that resident for IME and DGME purposes. This regulation allows medical residents to perform their duties in alternate locations, including their home or a patient’s home so long as it meets appropriate physician supervision requirements.

#### *AAFP Response*

The AAFP supports this policy change during the PHE.

### Merit-based Incentive Payment System Updates

#### *Summary*

In this regulation, CMS further modified its extreme and uncontrollable circumstances policy by extending the deadline from Dec. 31, 2019 to April 30, 2020 for COVID-19-related hardships. For the 2019 performance period, CMS specified that MIPS data submitted by a physician would be used even if the physician submitted a COVID-19-related hardship exception application.

CMS added a new improvement activity for the 2020 performance period related to COVID-19 pandemic. This improvement activity promotes participation in a COVID-19 clinical trial utilizing a drug or biological product. To receive credit for this clinical improvement activity, physicians must report findings through an open source clinical data repository or clinical data registry.

#### *AAFP Response*

The AAFP agrees with applying the extreme and uncontrollable circumstances policy to the 2019 performance year. The AAFP urges CMS to apply the extreme and uncontrollable circumstances policy to the 2020 performance year. We ask that CMS issue this guidance as soon as possible. The uncertainty regarding the 2020 performance year is a distraction to practices. Additionally, we encourage CMS to work with stakeholders to assess the long-term impacts of COVID-19 on quality measures and benchmarks and utilization.

### Advance Payments to Suppliers Furnishing Items and Services under Part B

#### *Summary*

To be more responsive to situations in which Part B suppliers could request advance payments from CMS, the agency modified its existing advance payments rules. Prior to the PHE, CMS limited advance payments to situations in which a CMS contractor was unable to process claims within established time limits.

Due to the pandemic and the inability to project the impact it may have in the future on CMS' abilities to ensure timely payment and the potential challenges for suppliers to prepare and submit claims to CMS contractors, CMS revised its policy to expand the circumstances under which it could make such conditional payments and specifically address emergency situations in which it will be able to make advance payments. Additionally, prior rules limited CMS to no more than 80 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid to the supplier. CMS increased this limit to 100 percent of the anticipated payment for that claim based upon the historical assigned claims payment data for claims paid to the supplier.

Finally, CMS added a criterion specifying that suppliers in bankruptcy would not be eligible to receive advance payment.

#### *AAFP Response*

The AAFP thanks the agency for increasing the payment limit from 80% to 100% and for making advance payments more readily available to physicians. Those payments were helpful to frontline physicians facing cash-flow difficulties in the midst of the pandemic.

We were deeply disappointed CMS subsequently chose to suspend the program on April 26, 2020. The AAFP urges CMS to immediately reopen the opportunity, for at least the duration of the PHE, in order to provide immediate financial relief to physicians. Through regulatory or

legislative actions, we also support the following policy changes to the Medicare Accelerated and Advance Payment Program:

- Postponement of the recoupment of disbursed funds until 365 days after the advance payment has been issued to a physician practice;
- Reduction of the per claim recoupment amount from 100% to 25%;
- Extension of the repayment period for physicians to two years;
- Reduction of the existing 10.25% interest rate accruing during the extended payment period to 1%; and
- Treatment of the payments through this program as if they were made from the General Fund of the U.S. Treasury.

These policy changes will support the efforts of practices to stay open throughout the length of the COVID-19 PHE and strengthen their ability to deliver services under a significantly impacted and altered environment. As the public gradually returns to physician offices to seek care, it is hoped that practices will reach their previous levels of service. The additional time before recoupment begins and the reduction in the amount recouped per claim will allow for a smoother transition for many practices. We appreciate that these policies would allow the practices to rebuild their volume of services by stabilizing their cash flow and revenues instead of dramatically recouping 100% of their Medicare claims.

The reduction of the interest rate for the Accelerated and Advance Payment Program will also afford physician practices additional relief. Physician practices will undoubtedly have to invest in additional telehealth and practice operation measures stemming from COVID-19, and the current 10.25% interest rate on funds would be just another impediment to implementing these much-needed adaptations. We are encouraged that the current interest rates are deemed by many as excessive under these circumstances and believe the lower rate is much more workable.

Lastly, during this unprecedented pandemic, we believe it is important to assure that any federal payment program does not adversely impact the Medicare Trust Fund or related indexes for calculating health care expenditures. Therefore, the AAFP supports the consideration of the payments from the Accelerated and Advance Payment Program being treated as a payment from the U.S. Treasury General Fund and not punitive against the Medicare program.

### Scope of Practice

#### *Summary*

CMS seeks comments in identifying additional Medicare regulations which contain more restrictive supervision requirements than existing state scope of practice laws, or which limit health professionals from practicing at the top of their license.

#### *AAFP Response*

As the pandemic continues to spread and more Americans become infected with the COVID-19 virus, it is imperative that our health care system be positioned to provide care in the most appropriate and timely manner. The AAFP strongly believes that care should be led by a physician. The AAFP opposes any regulation that undermines the physician-led team-based care models that have proven to be most effective in improving quality, efficiency, and most importantly, patient health. The AAFP believes that health professionals should work collaboratively as clinically integrated teams in the best interest of patients. Physician-led team-

based care addresses patients' needs for high quality, accessible health care and reflects the skills, training and abilities of each of the health care team members to the full extent of their state-based licenses. Furthermore, family physicians are particularly qualified to lead the health care team because they possess distinctive skills, training, experience and knowledge that allow them to provide comprehensive medical care, health maintenance, and preventative services for a range of medical and behavioral health issues.

#### Modified Requirements for Ordering COVID–19 Diagnostic Laboratory Tests

##### *Summary*

CMS states they are amending regulation to remove the requirement that certain diagnostic tests be covered only when ordered by a treating physician or NPP. Under the interim COVID-19 PHE policy, COVID tests, Influenza and RSV, may be covered when ordered by any HCP authorized to do so under state law. CMS proposes to allow Medicare coverage for COVID-19, influenza and respiratory syncytial virus testing when ordered for any health care provider under state law.

##### *AAFP Response*

We encourage CMS to require labs to report the test results to both the primary care physician and patient.

#### Requirements for Opioid Treatment Programs (OTP)

##### *Summary*

In the 2020 final Medicare physician fee schedule, CMS finalized allowing the use of interactive two-way audio/video communication technology to furnish the counseling and therapy portions of the weekly bundle of services furnished by OTPs. Due to the COVID-19 pandemic and because interactive audio-video communication technology may not be available to all beneficiaries, CMS is allowing the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls if beneficiaries do not have access to two-way audio/video communications technology, provided all other applicable requirements are met. CMS discusses that this change is necessary to ensure that beneficiaries with opioid use disorders can continue to receive these important services during the current PHE.

In light of the PHE for the COVID–19 pandemic, CMS proposes to revise on an interim final basis to allow opioid treatment programs (OTPs) to periodically assess patients via two-way interactive audio-video communication technology. If the beneficiary does not have access to two-way audio-video communications technology, the periodic assessments may be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology, provided all other applicable requirements are met.

##### *AAFP Response*

The AAFP supports efforts to address opioid use disorder and we agree that telehealth can play an important role in treating and coordinating care for beneficiaries with opioid use disorders. Expanding the range of approved platforms to include telephone audio only encounters will help ensure patients are receiving the care they need and prevent unnecessary morbidity and mortality during this pandemic.

Administrator Verma  
May 31, 2020  
Page 13 of 13

The AAFP supports this temporary change and we agree this policy ensures that beneficiaries with opioid use disorders are able to continue to receive these important services during the PHE for the COVID-19 pandemic.

Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 or [rbennett@aafp.org](mailto:rbennett@aafp.org) with any questions or to engage the AAFP further.

Sincerely,

A handwritten signature in black ink, appearing to read "John Cullen", written in a cursive style.

John Cullen, MD  
Board Chair