October 5, 2020
SUBMITTED ELECTRONICALLY VIA

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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program: CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Medicare Shared Savings Program Requirements; Quality Payment Program; etc.

Dear Administrator Verma:

In response to the Medicare Physician Fee Schedule (MPFS) Proposed Rule for Calendar Year (CY) 2021 (CMS-1734-P) (hereinafter, "Proposed Rule"), the American Academy of Home Care Medicine (Academy) is pleased to offer this comment letter.

The Academy has been serving the needs of thousands of home care medicine (HCM) professionals since 1988. Our members include home care physicians, nurse practitioners (NPs), and physician assistants (PAs) who make house calls, care for homebound patients, act as home health agency and hospice medical directors, and refer patients to home care agencies; home care organizations; medical directors of managed care plans; and administrators of medical groups interested in home care. Their specialties include internal medicine, family practice, pediatrics, geriatrics, psychiatry, and emergency medicine. The Academy delivers on the promise of interdisciplinary, high-value health care in the home for all people in need by promoting the art, science, and practice of home care medicine.

The Medicare beneficiaries we care for are home-limited due to multiple chronic illnesses, frailty, and disability. Our spectrum of services for our patients are specifically of a primary care nature, tailored to the unique needs of our population. As such, we refer to our services as Home-based Primary Care (HBPC).

The Academy supports several of the CMS proposals included in this Proposed Rule, and we provide comments in response to many of the issues that CMS has requested feedback on. A summary of the Academy's key recommendations include:

- **Redefining Evaluation and Management (E/M) Codes and Levels:** Although the Academy supports CMS efforts to ensure accurate reimbursement, we want to ensure that there are accurate

and appropriate reimbursements for all E/M services across the board including home and domiciliary visits. Under the budget neutrality rule, these codes will experience an average negative 10% adjustment. We urge CMS to reconsider how this adjustment will disproportionately affect its most sick and frail population, especially during the COVID-19 pandemic, and not apply a negative payment adjustment to home and domiciliary visit codes and instead adjust the RVUs for these codes to maintain the reimbursement at 2020 levels. As primary care services, HBPC services captured by these codes should be included under E/M enhancements tailored towards primary care practitioners; HBPC services should not be negatively impacted by being classified as specialty services.

- **Improving Access to Telehealth Services:** The Academy does not support the exclusion of home and domiciliary E/M codes from Categories 1 and 3, the removal of audio-only visit codes, or the 16-day data collection requirement for remote physiological monitoring (RPM). We urge CMS to include all levels of home and domiciliary E/M code range under at least Category 3, if not Category 1 of the Medicare Telehealth Services List. As well, we urge CMS to ensure that these services can continued to be provided via audio only technology and that appropriate standards are adopted for this complex patient population, especially considering their cognitive and physical needs.

- **Medicare Shared Savings Program (MSSP):** The Academy is supportive of the complex patient bonus for the MIPS Value Pathway (MVP) and APM Performance Pathway (APP) as well as the updated definition of primary care services used in beneficiary assignment. However, we urge the agency to consider changes to its ACO quality standards and methodology for determining shared savings and losses.

The Academy's detailed comments and recommendations in response to these and other proposals follow.

Redefining Office/Outpatient Evaluation/Management (E/M) Codes and Code Levels

Impact of Budget Neutrality

In the CY 2020 PFS final rule, CMS finalized new values for CPT codes 99202 through 99215, and assigned RVUs to the new office/outpatient E/M prolonged visit CPT code 99XXX, as well as the new HCPCS code GPC1X. CMS finalized a policy to adopt the new office/outpatient E/M visit codes with an effective date of January 1, 2021. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS adjusts to preserve budget neutrality.

While the Academy is supportive of ensuring accurate reimbursement for E/M services, it is imperative that there are accurate and appropriate reimbursements for all E/M services across the board, especially all primary care services, and not just for some settings or specialties at the expense of others. The budget neutrality provisions have a significant negative impact on HBPC services (i.e., home and domiciliary E/M codes). Specifically, the following home and domiciliary codes are being negatively adjusted by about 10% as demonstrated by the table below.

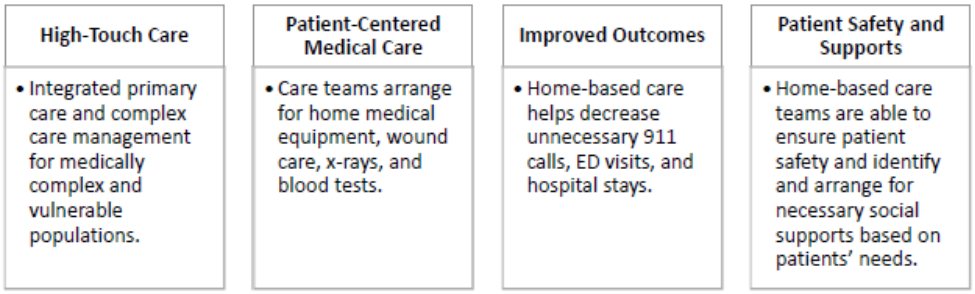
Setting	Patient	HCPCS	Payment Rates		Pct. Chg.	2018 ALLOWED SERVICES	2018 PAYMENT
			2020	2021			
Domiciliary	New	99324	$55.58	$50.00	-10.0%	51,069	$2,015,328
		99325	$80.84	$73.55	-9.0%	51,991	$2,987,429
		99326	$140.75	$129.04	-8.3%	57,719	$5,554,900
		99327	$189.11	$173.24	-8.4%	64,058	$8,114,860
		99328	$223.76	$204.21	-8.7%	40,211	$5,991,020
	Established	99334	$61.35	$56.78	-7.5%	481,904	$20,314,183
		99335	$97.08	$89.36	-8.0%	1,148,532	$75,387,582
		99336	$137.14	$126.78	-7.6%	1,566,395	$144,144,634
		99337	$197.77	$181.95	-8.0%	483,719	$63,866,723
Home	New	99341	$55.58	$50.33	-9.5%	14,454	$551,595
		99342	$79.76	$71.62	-10.2%	43,430	$2,510,162
		99343	$131.01	$118.07	-9.9%	56,213	$5,190,517
		99344	$185.86	$170.66	-8.2%	72,743	$8,952,846
		99345	$226.28	$207.76	-8.2%	65,393	$9,947,580
	Established	99347	$55.58	$50.97	-8.3%	196,332	$8,003,874
		99348	$85.53	$78.07	-8.7%	500,760	$30,217,749
		99349	$131.01	$120.98	-7.7%	1,122,906	$99,673,125
		99350	$182.61	$167.75	-8.1%	430,700	$53,518,649

These codes are used to support the delivery of primary care services in home and community settings, bringing care to the patient in a safe and comfortable setting. Office, home, and domiciliary code families have been modeled on one another by the CPT Editorial Panel to facilitate cross-walking valuations by the RUC for over two decades. When the Home Visit codes were initially valued (in 1997) they were determined to be more complex than the analogous office-based codes; when the Domiciliary/Group Home Codes were initially valued (in 2006), they were valued higher than the analogous Home Visit codes. Subsequent actions by the RUC have determined all three families to be essentially equivalent for over the past 10 years. Domiciliary and home visits have the same components as office visits and require similar levels of medical decision-making and therefore are closely analogous to the revalued codes. In particular, home and domiciliary services are the same as office/outpatient services in every way, except for the service location. They are relatively low volume services provided to a highly vulnerable population by professionals who are disproportionately affected by Medicare policy. We feel strongly that the precedents set by the RUC and CMS justifies maintaining the payment rates at equivalent levels.

Beneficiaries who receive HBPC services are complex and frail and the population that is at highest-risk for COVID-19 illness and death. HPBC practices are uniquely situated to mitigate the risk and spread of COVID-19 and other potentially widespread communicable diseases by keeping beneficiaries in their homes and out of higher-risk settings. Due to the nature of their work, HBPC providers are also more adept at managing risk as compared to other providers. During COVID-19, home-based care teams have demonstrated the ability to limit exposure risk for these vulnerable populations while continuing to provide medical care and manage beneficiaries' condition using telemedicine and advanced, point-of-service testing and monitoring technologies.

In a CMS press release published last month, the Agency emphasized the value of home and community-based care in not only being more cost-effective but also as a preferred alternative by seniors and adults with disabilities seeking to maintain the dignity of independent living. Medical care delivered in the home

creates value on many levels and accomplishes outcomes that would be difficult to obtain in a traditional care setting alone:



HBPC is already relatively underpaid as it relates to time and complexity due to the logistics of providing home and domiciliary E/M visits. Many HBPC practices often rely on alternative funding sources to help mitigate this undervaluation, which can be in the form of grants or subsidized support from larger health system. Further reductions to these codes threaten access to primary care services for the frailest and sickest population that often also lacks appropriate social and/or technological supports to care. This negative adjustment makes it difficult for physicians to continue providing care for this patient population as the sustainability of their practice is heavily dependent upon reimbursement for home and domiciliary E/M codes.

The Academy urges the Agency to consider the nursing facility care (99304 – 99318) and domiciliary (99324 – 99337) and home visits (99341 – 99350) to be analogous to the office/outpatient visit codes and make a positive adjustment to the work RVUs and reimbursements for those codes, and at a minimum to at least maintain payment rates at 2020 levels. The budget neutrality adjustment offers an opportunity to correct the relative underpayment for HBPC providers.

We understand that the RUC will be reviewing these codes in the near future so any increase in valuation by CMS would be temporary–likely for one or two years. Our primary concern is that beneficiaries continue to have access to these services in the near term and therefore we ask that CMS revise the work RVUs to the extent necessary to maintain the payment rate for these codes at 2020 levels. Additional changes in value can wait until the RUC reviews these codes and sends its recommendations to CMS. Given the relatively small volume of services reported under these codes, we do not expect that this change would negatively impact the conversion factor. Our estimate of the RVUs required to achieve this outcome are shown below.

Table 1
Recommended Work RVUs to Maintain 2020 Payment Rates

Setting	Patient	HCPCS	Recommend Work RVU
Nursing Facility	Initial	99304	1.90
		99305	2.70
		99306	3.52
	Subsequent	99307	0.88
		99308	1.33
		99309	1.79
		99310	2.69
	Discharge Service	99315	1.48
		99316	2.19
	Annual nursing facility assessment	99318	1.96
Domiciliary	New	99324	1.18
		99325	1.75
		99326	2.99
		99327	3.95
		99328	4.70
	Established	99334	1.21
		99335	1.96
		99336	2.78
		99337	4.07
Home	New	99341	1.17
		99342	1.77
		99343	2.93
		99344	3.85
		99345	4.66
	Established	99347	1.14
		99348	1.79
		99349	2.64
		99350	3.74

We also ask CMS to consider allowing the complexity adjustment code (GPC1X) to be reported with these codes.

Coding Documentation for E/M Service Level

In the CY 2020 MPFS Final Rule, CMS finalized a policy to adopt a new coding guidance framework effective January 1, 2021. Under this new CPT coding framework, history and exam will no longer be used to select the level of code for office/outpatient E/M visits, specifically for CPT codes 99201 through 99215. Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed. For levels 2 through 5 office/outpatient E/M visits, selection of the code level to report will be based on either the level of the medical decision making (MDM) or total time personally spent by the reporting practitioner on the day of the visit.

The Academy commends CMS efforts in reducing administrative burden and updating its code sets to better reflect the current practice of medicine. However, we would encourage the Agency to extend these documentation flexibilities to home and domiciliary visit codes. Based on the referenced codes, CPT 99201-99214, it would be appropriate that the changes apply to other outpatient settings and not just in-office visits. The application of this policy for AAHCM providers significantly reduce coding complexity and paperwork burden. Many providers, especially those parts of health systems, treat patients in multiple settings. It will be incredibly confusing and burdensome for primary care providers to have to remember and utilize different coding and documentation guidelines depending on the setting the patient is seen in. (e.g., Geriatric Clinic and house call days, inpatient palliative and in-home primary based care).

Improving Access to Telehealth Services

Medicare Telehealth Services List – Category 1

After considering public requests for adding Category 1 services to the Medicare telehealth list, identifying services through an internal review for addition to the list, and reviewing the services added on an interim basis during the COVID-19 public health emergency (PHE), CMS is proposing to add the following to the Medicare telehealth services list on a Category 1 basis for CY 2021: 99334/99335 (Domiciliary, Rest Home, or Custodial Care services) & 99347/99348 (Home Visits). CMS notes that while the home is generally not a permissible telehealth originating site, the domiciliary/home visit services could be billed as telehealth only for treatment of a substance use disorder or co-occurring mental health disorder under the flexibility afforded by the SUPPORT for Patients and Communities Act.

The Academy supports CMS efforts to increase access to telehealth services by permanently adding certain services to its Category 1 list. However, allowing domiciliary and home visit codes to be billed as telehealth only for the treatment of a substance use disorder or co-occurring mental health disorder under the SUPPORT Act is limiting. HBPC patients with other serious conditions also highly benefit from telehealth visits. CMS should include all levels of service for the home and domiciliary CPT code range under Category 1 for CY 2021:

- New Patient Home Visit CPT range 99341-99345 and Established Patient Home Visit Range CPT 99347-99350
- New Patient Domiciliary CPT range 99324-99328 and Established Patient Domiciliary Range CPT 99334-99337

This ensures that seniors have continued access to telehealth services beyond the PHE if and/or when there is a legislative change to revise the originating site and geographic restrictions so patients can receive care where they are.

Medicare Telehealth Services List – Category 3

CMS is proposing to create a new category of criteria – Category 3 – for adding services to the Medicare telehealth list on a temporary basis through the end of the calendar year in which the PHE ends:

99336/99337 (Domiciliary, Rest Home, or Custodial Care services, Established patients) & 99350 (Home Visits, Established Patients).

We appreciate CMS continuing telehealth flexibilities through the end of the calendar year in which the PHE ends. However, as stated above, the Academy believes CMS should include all levels of service for the home and domiciliary CPT code range under at least Category 3, if not Category 1.

- New Patient Home Visit CPT range 99341-99345 and Established Patient Home Visit Range CPT 99347-99350
- New Patient Domiciliary CPT range 99324-99328 and Established Patient Domiciliary Range CPT 99334-99337

Providers do not know the level of service they will report before seeing a patient as it either depends on the level of complexity presented during the visit and/or how much overall time may have been spent on counseling and coordination of care. The current proposed rule only includes level 1-2 established patient home visit levels of service, which are the least commonly reported according to national E/M benchmark data. These populations face disproportionately high access and equity issues. Patients that are home-limited typically have multiple comorbidities in addition to challenging medical, functional, and social issues that are addressed during comprehensive HBPC assessments. Additionally, CMS included the two highest levels of domiciliary codes but no lower levels of service. This could pose a concern for abuse as there are no permanent lower level domiciliary visit codes available under Category 1 if it were a less complex problem to address an acute uncomplicated problem. Finally, for all telehealth services, CMS should provide clear guidance on the billing requirements, for example, when a modifier is or is not required and which modifier should be billed. This will reduce unnecessary billing burden for physicians who are trying to ensure they can continue providing care for their complex patient population.

Remote Physiologic Monitoring (RPM) Services

Auxiliary Personnel

CMS is proposing to allow auxiliary personnel to furnish services described by CPT codes 99453 and 99454 under general supervision of the billing physician or practitioner.

- 99453 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate
- 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

The Academy supports CMS expanding scopes of practice for auxiliary personnel. As physicians go into the community and patients' homes, we find it helpful to have other members of the interdisciplinary team assisting in furnishing certain services.

Data Collected Within A Given Period

After the PHE, CMS will revert to requiring that these services are furnished to established patients and require that 16 days of data be collected within 30 days to meet the requirements for CPT codes 99453 and 99454. CMS is seeking comment on whether the current RPM coding accurately and adequately describes the full range of clinical scenarios that RPM services may benefit patients. Specifically, CMS notes that some patients may not require remote monitoring for 16 days or more in a 30-day period, and that for some patients, continuous short-term monitoring might be more appropriate (e.g., several times a day, over a period of 10 days, etc.).

We would like to caution requiring 16 days of data to be collected within a 30-day period and urge CMS to adopt a different standard that takes into account populations with cognitive and physical issues, such as those with dementia and ADL needs. Unless a device is continuously running, it is unlikely to be able to collect enough data to meet this requirement, especially for the home care medicine patient population. These patients often require assistance with activities of daily living (ADLs) and may either forget to put or turn on their medical device on a consistent basis within a 30-day period. However, the data collected through RPM is still valuable and informative for patient care and monitoring, and still needs to remain an option for this patient population. The Academy agrees with CMS that some patients may not require remote monitoring for 16 days or more in a 30-day period, and that for some patients, continuous short-term monitoring might be more appropriate such those with hypertension and asthma. We recommend that CMS remove the 16-day requirement and consider other costs of RPM services not currently covered under existing codes such as delivery costs associated with providing equipment, preventative maintenance efforts, and internet/network access for patients limited to device use. Most devices today used for RPM services offer embedded technology that connects to a network that providers pay to access on behalf of the patient. This network access is limited to the transmission of data from the assigned device and is an incremental cost to providers who provide care in underserved areas.

Audio-only Visit Codes

CMS is proposing to stop recognizing these codes as covered services under the PFS after the end of the PHE because, outside the context of the PHE, CMS is unable to waive the requirement that telehealth services be furnished using interactive telecommunications systems that include two-way, audio/visual communication technology.

The Academy cautions against removing audio-only visit codes after the PHE. Post COVID-19, many physician practices, and the patients they serve will continue to remain heavily reliant on telehealth services for the foreseeable future. Removing the codes will disproportionally put patients without a means to technology or access to the internet at risk of not having access to care. Many complex home-limited patients are without wi-fi, computers, or smart devices or may be cognitively or physically impaired in using video technology. Therefore, they require medical intervention and guidance via audio-only telephone calls when they are not receiving in-person care. The Academy urges CMS to permanently implement a separate payment for telephone-only services that specifies what is included in the telephone visit. This could mean creating time-based codes for E/M (additive over 7 days). This would be incredibly valuable for providers providing a telephonic visit to complex patients when the work is separate and distinct from care management services such as chronic care management.

Direct Supervision

CMS is proposing to extend the policy that direct supervision can be satisfied by the virtual presence of the supervising physician/practitioner using interactive audio/video real-time communications technology to the later end of the calendar year in which the PHE ends or December 31, 2021. The Academy supports this proposal to allow direct supervision to be satisfied by the virtual presence of the supervising physician/practitioner. We believe it increases access to care especially during the COVID-19 pandemic.

Delineating Scopes of Practice and Related Issues

Supervision of Diagnostic Tests by Certain NPPs

CMS is proposing to amend the regulations on a permanent basis to specify that supervision of diagnostic psychological and neuropsychological testing services can be done by nurse practitioners (NPs), certified nurse specialists (CNSs), physician assistants (PAs), or certified nurse-midwives (CNMs) to the extent that they are authorized to perform the tests under applicable State law and scope of practice. CMS is proposing,

on a permanent basis, that diagnostic tests performed by a PA in accordance with their scope of practice and State law do not require the specified level of supervision assigned to individual tests. CMS is proposing to permanently remove the requirement for a general level of physician supervision for diagnostic tests performed by a PA. We are supportive of this proposal that clarifies the level of care NPPs can provide. We believe the removal of certain supervision requirements will expand access to COVID-19 diagnostic testing.

Home Infusion Therapy Services

CMS is proposing that for home infusion therapy services effective beginning CY 2021, physicians are expected to continue their current practice of discussing options available for furnishing infusion therapy under Part B and documenting their discussions in their patients' medical records prior to establishing a home infusion therapy plan of care. There will not be a mandatory form or guideline on how physicians need to inform their patients. The Academy supports this proposal and appreciates the flexibility afforded to providers.

Medicare Shared Savings Program (MSSP)

Establishing a Smaller Measure Set for ACOs

CMS is proposing to decrease the number of measures from 23 to 6, and the number of actively reportable measures from 10 to 3. The proposed APP would replace the current Shared Savings program quality measure set to simplify reporting requirements. The new APP framework would also be weighted different, with quality accounting for 50 percent, PI accounting for 30 percent, IA accounting for 20 percent, and cost accounting for 0 percent. ACOs would be scored on the measures they choose to report but would receive zero points for those they do not report. Further, CMS proposes to remove the phase in approach for quality reporting. Regardless of performance year and agreement period, all ACOs would be scored on the same 3 actively reportable quality measures: 1) Diabetes: Hemoglobin A1C Poor Control (>9%); 2) Preventive Care and Screening: Screening for Depression and Follow-Up Plan; and 3) Controlling High Blood Pressure.

While we appreciate the more streamlined measures for quality reporting and decreasing the total number, 2 of the 3 measures (A1c and controlling high blood pressure) are not appropriate for this patient population. Current measures in the MSSP, as well as other Medicare programs and models, are not clinically appropriate or applicable to a frail, seriously ill, and home-limited patient population (i.e., those treated by home care medicine practices). We are concerned that even though physicians are delivering high-touch, high-quality, and clinically appropriate care to this medically complex patient population, they are penalized under these programs due to the quality measures. Additionally, this deters others from participating in the program. Thus, we urge CMS to adopt a more clinically appropriate measure set that is inclusive of complex, chronic care patients. We recommend 2 replacement measures from the Home Based Primary and Palliative Care Data Registry: 1) Telephone Contact, Virtual, or In-person Visit Within 48 Hours of Hospital Discharge of Home-Based Primary Care and Palliative Care Patients, and 2) Medication Reconciliation within 2 Weeks of Hospital Discharge of Home-Based Primary Care and Palliative Care Patients. Additionally, we request that CMS review the following publication that identifies large gaps in which home visits are not included in meaningful measures: *To What Extent Are the Centers for Medicare & Medicaid Services 2019 MIPS Quality Measures Inclusive of Home-Based Medical Care?* We would be happy to meet and discuss further with the Agency.

Revising the Shared Savings Program Quality Performance Standard

CMS is proposing to raise the quality performance standard for all ACOs from the 30th percentile to the 40th percentile across all MIPS quality performance category scores, with the exclusion of providers

eligible for facility-based scoring. CMS conducted a data analysis using 2018 reporting data that showed 95 percent of ACOs would meet the new 40th percentile requirement.

While the Academy recognizes that a trade-off exists between setting an appropriate quality standard and the use of suitable measures, we do not support raising the overall quality performance standard. Given the chronic and complex care population we serve, our providers already find it difficult to meet the current 30th percentile requirement. Many quality measures are not appropriate for our patient population and raising the standard would unjustly penalize those ACOs providing care to the tail end of patient population. HBPC physicians participating in ACOs often care for the most-sick patients in the system with multiple chronic conditions that would otherwise be bound to long-term institutional care settings.

Updating the Definition of Primary Care Services Used in Beneficiary Assignment

CMS is proposing to include certain codes for technical changes to the definition of primary care starting January 1, 2021. CMS is proposing to revise the following primary care services codes to account for online digital E/M, assessment of and care planning for patients with cognitive impairment, chronic care management, non-complex chronic care management, principal care management, and psychiatric collaborative care management. CMS defines online digital evaluation, or e-visits, to be non-face-to-face, patient-initiated communications using online patient portals. The chronic disease management code requires two or more chronic conditions that place the patient at a significant risk of death or co-morbidities. Other requirements are applied to the following new codes: non-complex chronic care management, principal care management, and psychiatric collaborative care management.

We are supportive of this proposal to update the definition of primary care services. We support the inclusion of the HCPCS code G2010 (virtual communication) as well.

Methodology for Determining Shared Savings/Losses based on ACO Quality Performance

For all tracks, CMS is proposing to revise the regulations and requirements that ACOs must meet to qualify for a shared savings payment beginning on January 1, 2021. If the ACO is eligible to share in savings and meets the proposed quality performance standard, the ACO will receive the maximum sharing rate up to the performance payment limit. However, if an ACO fails to meet the proposed quality performance standard, the ACO would be ineligible to share in savings. CMS is also proposing to modify the methodology for determining shared losses under Track 2 and the ENHANCED track. The new calculation for calculating shared losses would begin on January 1, 2021. The quality score of the ACO will also be used to calculate shared losses.

We commend the Agency in its efforts to continuing to support ACOs that serve complex, high-cost, and frail patients. However, the Academy believes that there needs to be a more appropriate shared savings methodology for ACOs that serve a disproportionately complex, frail, and functionally limited population. It will be helpful to apply both a 2.5% regional adjustment cap and a frailty risk adjustment for ACOs that primarily care for complex, frail patient populations. Additionally, patients that fall under the categories listed above qualify for institutionalization but instead are provided home-based primary care services allowing patients to remain in their home. We urge CMS, if possible, to retroactively apply these adjustments to PY 2020. It may also be beneficial to consider if ACOs participating in the enhanced track, that are treating especially sick populations, should be regionally adjusted at all. Alternative models to regional adjustment should be considered.

ACO Attribution

For NP owned and/or practices primarily staffed by NPs, it is a difficult task to ensure patients are properly attributed to the practice due to several reasons. Most NP driven practices do not have a physician to

complete E/M and/or annual well visits (AWV) and patients are not being linked via NP billing. The normal claims-based attribution does not work for these providers with many finding it hard to walk patients through MyMedicare.gov, especially because the support team for the site can only speak directly to patients. Due to the age and diagnoses of our population, patients generally face challenges with technology and have a difficult time understanding why our providers require them to complete this task. Patients are also receiving errors stating that their ID number could not be found even though providers are utilizing the proper number, as it is what the practices are billing with.

We urge CMS to immediately change the claims data process in order for it to work properly for both medical doctors and NPs. Practices should also be able to obtain consent and complete the selection for the patient. As CMS shifts more towards value-based care, NPs need an efficient claims process that allows them to focus their attention on treating patients. These difficulties limit their ability to receive reimbursement for the work they are doing to care for our frail population. We further recommend, due to the changes to the website, that the attribution period be extended through the end of November to ensure that patients and providers have adequate time to complete the process.

MIPS Value Pathway (MVP) and APM Performance Pathway (APP)

CMS is proposing to continue the complex patient bonus for the 2021 performance period (2023 payment period). Furthermore, to adjust for the increased complexity due to the COVID-19 PHE, CMS is proposing to double the complex patient bonus score ECs can receive during the 2020 performance period (2022 payment period), with a cap at 10 points. The Academy is supportive of this proposal to continue the complex patient bonus, as well as the proposal to double the bonus score ECs can receive during the 2020 performance period. We believe that these populations should receive risk adjustments more frequently.

Conclusion

We thank you for the opportunity to provide input on this Proposed Rule and we look forward to continuing to work with CMS to ensure that access and quality care are available to the sickest, frailest, most vulnerable home limited beneficiaries. If you have any questions regarding this letter, please contact Brent Feorene, Executive Director, at bfeorene@aahcm.org.

Sincerely,

Eric De Jonge, M.D.
American Academy of Home Care Medicine
Public Policy Chair