

## Vizient Office of Public Policy and Government Relations

### **Medicare and Medicaid Programs, Basic Health Program, and Exchanges; 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 (Interim final rule with comment period)**

May 6, 2020

#### **Background and Summary**

On April 30, CMS issued an interim final rule, "[Medicare and Medicaid Programs, Basic Health Program, and Exchanges; 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](#)" (hereinafter, IFC). In the IFC, which has a 60-day comment period, CMS makes several policy changes that build upon and expand previous telehealth policies, remove barriers to support care provided in alternative sites and provides additional clarity regarding the Medicare Shared Savings Program and the Hospital Value-Based Purchasing Program. In addition, the IFC seeks to increase access to testing and clarify related billing issues. The IFC was made available on April 30, 2020. The policies are generally applicable beginning on either January 27, 2020 (start of the Public Health Emergency) or March 1, 2020, (start of the national emergency) until the end of the COVID-19 Public Health Emergency. Comments will be accepted until July 7, 2020.

This summary includes key provisions most relevant to hospitals and health systems.

#### **Hospitals Without Walls**

##### **Treatment of Certain Relocating Provider-Based Departments (PBDs) During the COVID-19 Public Health Emergency (PHE)**

- CMS will temporarily expand its extraordinary circumstances relocation policy so that certain PBDs that relocate on or after March 1, 2020 for the purposes of addressing COVID-19 can bill at the outpatient prospective payment system (OPPS) rate, as opposed to rates established under the Physician Fee Schedule (PFS). An application is required for this exception.
  - o CMS anticipates that most PBDs that relocate during the PHE will relocate back to their original location prior to, or soon after, the conclusion of the PHE. If the PBD does not go back to their original location, they will be considered non-excepted PBDs (for purposes of the Bipartisan Budget Act of 2015) and paid at the PFS-equivalent rate.
- CMS provides information related to billing and the process for requesting application of the extraordinary circumstance relocation exception related to COVID-19.
  - o Relocating hospitals with on-campus and excepted off-campus PBDs should include modifier "PO" on OPPS claims for services furnished at the relocated PBD; the modifier indicates a service is provided at an excepted off-campus PBD and is paid under OPPS.
  - o Within 120 days of beginning to furnish and bill for services at the relocated PBD, hospitals must email their CMS Regional Office with hospital-specific information, a justification for the relocation and the role of the relocation in the hospital's response to COVID-19, and an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.

- If hospitals will be rendering services in relocated excepted PBDs but intend to bill Medicare for the services under the main hospital, no additional provider enrollment actions are required for the off-campus relocated site during the PHE.

**Furnishing Hospital Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (CMHC) (Including the Patient’s Home)**

- CMS considers hospital outpatient therapeutic services in three categories and provides several billing considerations as noted in the below table.

<b>CMS Category</b>	<b>Billing Considerations</b>
Hospital outpatient therapy, education, and training services, including partial hospitalization program services, that can be furnished other than in-person, and are furnished in a temporary expansion location (may be the patient’s home) that is a PBD of the hospital or an expanded CMHC.	<ul style="list-style-type: none"> <li>• Hospitals may bill for these services as if they were furnished in the hospital.</li> <li>• If incident-to services are provided and those services are not provided by hospital staff, the hospital would not bill for the services; the physician or hospital would bill for the incident to services and be paid under the PFS.</li> <li>• The IFC provides additional information for the Partial Hospitalization Program.</li> </ul>
Hospital outpatient clinical staff services furnished in-person to the beneficiary in a temporary expansion location (which may be at the home).	<ul style="list-style-type: none"> <li>• The hospital should be aware if the patient is under a home health plan of care and only furnish those services that cannot be furnished by the home health agency (HHA).</li> <li>• Hospitals should only consider the patient’s home to be provider-based to the hospital when the patient is registered as a hospital outpatient.</li> <li>• Hospitals should bill for these services as they ordinarily bill for services and adhere to billing requirements for relocated PBDs during the PHE.</li> </ul>
Hospital services associated with a professional service delivered by telehealth.	<ul style="list-style-type: none"> <li>• If a registered outpatient of the hospital is receiving a telehealth service, the hospital may bill the originating site facility fee to support such telehealth services furnished by a physician or practitioner who ordinarily practices there. This includes patients who are at home, when the home is made provider-based to the hospital under the policies in effect for COVID-19.</li> <li>• The home would be the PBD of the hospital and the originating site for the telehealth service furnished by a physician or practitioner located at a distant site.</li> </ul>

## Telehealth

### Payment for Audio-Only Telephone Evaluation and Management (E/M) Services

- CMS added Medicare coverage of and payment for telephone E/M codes (99441-99443) in March 2020. Now, CMS is increasing payment by establishing new RVUs for these services that are more similar to the office/outpatient E/M codes, and crosswalking CPT codes as follows:
  - o 99212 to 99441 (0.48 work RVUs)
  - o 99213 to 99442 (0.97 work RVUs)
  - o 99215 to 99443 (1.50 work RVUs)
  - o Note: CMS has separately issued a [waiver](#) to the requirement that telehealth services must be furnished using video technology
- CMS highlighted that it did not increase payment rates for certain other telephone assessment and management services provided by a qualified nonphysician health care professional (CPT codes 98966-98968) since these services are furnished by practitioners who cannot independently bill for E/M services.
- CMS seeks comment on how best to minimize unexpected cost sharing for beneficiaries (beneficiaries are still liable for cost-sharing for these services in instances where the practitioner does not waive cost-sharing).

### Additional Telehealth Updates

- CMS modified a policy provided on March 31, which indicated that typical times associated with office/outpatient E/M visit (as described in CMS's public use file) are what should be met for purposes of level selection for an office/outpatient E/M visit. The typical times are different from the times listed in the CPT code descriptors. Now, CMS has indicated the typical times for purposes of level selection for an office/outpatient E/M visit are the times listed in the CPT code descriptor.
  - o This clarification was provided because the physician community indicated there was confusion due to inconsistency between typical times listed in [CMS's public use file](#) and the office/outpatient E/M CPT code descriptors.
- CMS will now use a subregulatory process (e.g., posting new services to the web listing of telehealth services when the agency receives a request to add a service) when modifying the telehealth list. Services added using this revised process would remain only for the duration of the PHE.
  - o CMS issued a [waiver](#) to authorize additional providers to furnish telehealth services, including speech-language pathologists, occupational therapists, and physical therapists.

### Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the COVID-19 Public Health Emergency

- CMS is expanding opportunities for RPM services by allowing services to be furnished for shorter episodes of care (2-16 days during a 30-day period), assuming other requirements for billing are met.
  - o Payment for CPT codes 99454, 99452, 99091, 99457 and 99458 under the modified timeline is limited to patients who have a suspected or confirmed diagnosis of COVID-19.

## Testing

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

- CMS is removing the requirement that certain diagnostic tests are covered only if there is an order from treating physician or nonphysician practitioner (NPP); Medicare will cover a COVID-19 test when ordered by any healthcare professional authorized to do so under state law, which may include pharmacists. CMS expects the entity submitting the claim to include the ordering or referring national provider identifier (NPI) information on the claim form when an order is written for the test, consistent with current billing instructions.
  - o If there is no physician or NPP order, the [laboratory](#) conducting the tests must directly notify the patient of the results consistent with other applicable laws and test reporting requirements (e.g., reporting to state or local officials).
  - o CMS will make a list of diagnostic laboratory tests (e.g., tests for influenza virus and respiratory syncytial virus) for which they are removing the ordering requirements publicly available; these tests would need to be furnished in conjunction with a COVID-19 test as medically necessary.
- CMS is removing certain documentation and recordkeeping requirements associated with COVID-19 test orders which would not be relevant if there is no treating physician's or NPP's order.

### Flexibility for Medicaid Laboratory Services

- The Families First Coronavirus Response Act added in vitro diagnostic products for COVID-19 (including serological tests) and the administration of such products as a mandatory Medicaid benefit.
- Retroactive to March 1, 2020, CMS is broadening coverage of COVID-19 tests, including those administered in non-office settings and when a laboratory processes self-collected COVID-19 tests that are FDA-authorized for self-collection.
  - o This flexibility applies during the PHE and subsequent "periods of active surveillance" which CMS defines as during an outbreak of a communicable disease during which no approved treatment or vaccine is widely available. It would terminate when indicated by the Secretary, or the date which is two incubation periods after the last known case of the communicable disease, whichever is sooner.
- CMS seeks comments on the definition of a "period of active surveillance".

### Supervision of Diagnostic Tests by Certain Nonphysician Practitioners

- CMS will cover certain diagnostic tests when nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs) provide the appropriate level of supervision and in accordance with state law.
- CMS also modified supervision of COVID-19-related diagnostic psychological and neuropsychology testing services to allow these services to be supervised by a NP, CNS, PA and CNM (in addition to physicians and clinical psychologists (CPs)).
- CMS is allowing PAs without physician supervision to perform diagnostic tests.

### COVID-19 Serology Testing

- Medicare will cover FDA-authorized COVID-19 serology tests for beneficiaries with known current or known prior COVID-19 infection, or suspected current or suspected past COVID-19 infection. CMS would expect to be billed once per sample and would not expect these tests to be performed and billed unless clinically indicated.

## **Payment for COVID-19 Specimen Collection to Physicians, Nonphysician Practitioners and Hospitals**

- CMS is providing additional payment for assessment and COVID-19 specimen collection to support testing by hospital outpatient departments (HOPDs), physicians and other practitioners.
  - o Physicians and NPPs may use CPT code 99211 for new and established patients to bill for a COVID-19 symptom and exposure assessment and specimen collection provided by clinical staff incident to their services.
  - o For HOPDs, CMS is establishing a new E/M code solely to support COVID-19 testing for the PHE: HCPCS code C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)(coronavirus disease [covid-19], any specimen source).
    - HCPCS code C9803 will be assigned to APC 5731 Level 1 Minor Procedures and a status indicator of “Q1” to indicate it will be conditionally packaged under OPPS.
    - A separate payment for CPT code C9803 will be made when it is billed with a clinical diagnostic laboratory test with a status indicator of “A” on Addendum B of the OPPS.
- Generally, cost-sharing for specimen collection (e.g., CPT code 99211 and HCPCS code C9803) will be waived when certain requirements are met, such as when it results in an order for or administration of a COVID-19 test.

## **Medical Education**

### **Bed Counts**

- For determining a hospital’s indirect medical education (IME) payment amount, the hospital’s available bed count is considered to be the same as it was on the day before the COVID-19 PHE was declared. Beds temporarily added during the PHE are excluded from the calculations to determine IME payments.

### **Time Spent by Residents at Alternative Locations During the COVID-19 PHE**

- For the purposes of IME and direct graduate medical education (DGME) payments, teaching hospitals may claim the time spent by residents training at other hospitals (during the PHE). The following conditions and other applicable requirements are met:
  - o The resident is sent to another hospital in response to COVID-19 (either hospital can be treating COVID-19 patients).
  - o Time spent by the resident at the other hospital would be considered time spent in approved training if the activities performed by the resident are consistent with any guidance in effect during the COVID-19 PHE for the approved medical residency program at the sending hospital.
  - o The time that the resident spent training immediately prior to and/or subsequent to the timeframe that the PHE was in effect was included in the sending hospital’s full time equivalent (FTE) resident count.
- If the teaching hospital claims the resident’s time, no other hospital, teaching or non-teaching, would be able to claim that time.
- During the PHE, the presence of residents in non-teaching hospitals will not trigger establishment of per resident amounts or FTE resident caps at those non-teaching hospitals.

- If a resident is performing duties within the scope of the residency program and physician supervision requirements are met, then hospitals paying the resident's salary and fringe benefits for that time may claim that resident for IME and DGME purposes.

### **Additional Flexibility Under the Teaching Physician Regulations**

- CMS added to the list of services that Medicare may make PFS payment to the teaching physician when furnished by a resident under the primacy care exception; a resident may furnish the following services:
  - o CPT Codes 99441 – 99443
  - o CPT Codes 99495 – 99496
  - o CPT Codes 99421 – 99423
  - o CPT Code 99452
  - o HCPCS Codes G2012 and G2010
- CMS clarified the office/outpatient E/M level selection for services under the primary care exception when furnished via telehealth can be based on medical decision making (MDM) or time (all of the time associated with the E/M on the day of the encounter). In addition, CMS noted the requirements regarding documentation of history and/or physical exam in the medical record do not apply.

### **Rural Health Clinics (RHC)**

- CMS will use the number of beds from the cost reporting period prior to the start of the PHE (January 27, 2020) as the official hospital bed count when determining whether a provider-based RHCs is excepted from the per-visit payment limit because the hospital has fewer than 50 beds.

### **Update to the Hospital Value-Based Purchasing (VBP) Program Extraordinary and Extreme Circumstances Policy**

- CMS is permanently revising the disaster/extraordinary circumstance exception (ECE) policy to allow CMS to grant an exception to hospitals located in an entire region or locale (including the entire United States) affected by extraordinary circumstance, even if the hospital has not requested the exception.
- CMS is granting an ECE with respect to the COVID-19 PHE to all hospitals participating in the Hospital VBP program for the following reporting requirements:
  - o Hospitals will not be required to report National Healthcare Safety Network (NHSN) HAI measures and HCAHPS survey data for the following quarters:
    - October 1, 2019 – December 31, 2019 (Q4 2019)
    - January 1, 2020 – March 31, 2020 (Q1 2020)
    - April 1, 2020 – June 30, 2020 (Q2 2020)
    - Note: Hospitals have the option to submit part or all of the data by the submission deadlines on the [HVBP QualityNet site](#)
  - o CMS will exclude qualifying claims data from the mortality, complications, and Medicare Spending per Beneficiary measures for the following quarters:
    - January 1, 2020 – March 31, 2020 (Q1 2020)
    - April 1, 2020 – June 30, 2020 (Q2 2020)
- CMS will continue to retain the individual ECE request policy.
- CMS will continue to monitor the impact of COVID-19 and will communicate any other exceptions and/or extensions

## **Merit-Based Incentive Payment System (MIPS) Qualified Clinical Data Registry (QCDR) Measure Approval Criteria**

- CMS is delaying implementation of the completion of the QCDR measure testing policy and the requirement to collect data on QCDR measures:
  - o Beginning with the 2022 performance period (as opposed to the 2021 performance period), all QCDR measures must be fully developed and tested, with complete testing results at the clinical level, prior to submitting the QCDR measure at the time of self-nomination for approval for the MIPS performance period.
  - o Beginning with the 2022 performance period (as opposed to the 2021 performance period), QCDRs are required to collect data on a QCDR measure for CMS consideration during the self-nomination period.
  - o During the 1-year delay, CMS will continue to review QCDR measures and review the evidence provided by the QCDR that would support the need for measurement if there is insufficient data to demonstrate that is a measurement gap.

## **Medicare Shared Savings Program (MSSP)**

### **ACO Application Cycles and Participation Agreements**

- CMS is forgoing the application cycle for a January 1, 2021 start date:
  - o CY 2020 will not serve as a benchmark year 3 for a cohort of ACOs that would otherwise start January 1, 2021.
  - o CMS indicated eligible currently participating ACOs will be able to apply for a SNF 3-day rule waiver, apply to establish a beneficiary incentive program, modify list of ACOs participant(s) and/or SNF affiliates, and elect to change their assignment methodology for performance year (PY) 2021.
- For the 160 ACOs whose Shared Savings Program participation agreements will expire December 31, 2020, they may apply to renew their participation agreement for the Shared Savings Program effective January 1, 2021.
  - o If the ACOs entered a first or second agreement period with a start date of January 1, 2018, they may either:
    - Elect to extend their agreement period for an optional fourth performance year (January 1, 2021 – December 31, 2021); or
    - Conclude participation in the program with the expiration of its current agreement period (December 31, 2021).
- CMS seeks comment on their approach to the extension of participation agreements scheduled to expire on December 31, 2020.

### **Expansion of Codes Used in Beneficiary Assignment**

- CMS is revising the definition of primary care services used in assignment of beneficiaries to ACOs to include services provided virtually, either through telehealth, virtual check-ins, e-visits, or telephone.
- CMS seeks comment on the revisions to the definition of primary care services adopted in this IFC.

### **Shared Savings Program Extreme and Uncontrollable Circumstances Timeline**

- CMS modified its March 2020 statement and now, for the purposes of the Shared Savings Program, the months affected by an extreme and uncontrollable circumstance will be January 2020 until the end of the PHE.

- If the PHE extends through all of CY 2020, all shared losses for PY 2020 will be mitigated for all ACOs participating in a performance-based risk track (this includes Track 2, the ENHANCED track, Levels C, D, and E of the BASIC track and the Track 1+ Model).
  - o For example, since the PHE has covered 4 months, any shared losses an ACO incurs for PY 2020 will be reduced by at least one third. If the PHE runs for the entire year, the ACO shared losses would be reduced completely and none would be owed.

### **Shared Savings Program Calculations to Address COVID-19**

- CMS is excluding from Shared Savings Program's calculations all Part A and B fee-for-service (FFS) payment amounts for an episode of care for treatment of COVID-19, triggered by either:
  - o Discharges for inpatient services eligible for the 20 percent DRG adjustment; or
  - o Discharges for acute care inpatient services for treatment of COVID-19 from facilities that are not paid under the IPPS, such as CAHs, when the date of admission occurs within the COVID-19 PHE.
- CMS will adjust the following Shared Savings calculations to exclude all Parts A and B FFS payment amounts for a beneficiary's episode of care for COVID-19:
  - o Calculation of a Medicare Parts A and B FFS expenditures for an ACO's assigned beneficiaries for all purposes (e.g., establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures).
  - o Calculation of FFS expenditures for assignable beneficiaries as used in determining county-level FFS expenditures and national Medicare FFS expenditures. The IFC provides 5 examples of such calculations.
  - o Calculation of Medicare Parts A and B FFS revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track as specified in regulation.
  - o Calculation of total Medicare Parts A and B FFS revenue of ACO participants and total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for purposes of identifying whether an ACO is high or low revenue and determining an ACO's eligibility for participation options.
  - o Calculation or recalculation of the amount of the ACO's repayment mechanism arrangement according to regulation.
- CMS will not account for recoupment of accelerated or advanced payments or payments under the Provider Relief Fund in the calculations as these occur outside the FFS processing system.
- CMS seeks comment on the approach to adjusting program calculations.

### **Certification and Provision of Home Health Services**

- CMS is revising certain regulations to include physician assistants, nurse practitioners, and clinical nurse specialists among the individuals who can certify the need for home health services and order services.
  - o These changes are permanent (beyond the PHE) and applicable to services provided on or after March 1, 2020.

### **Requirement for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19**

- Beginning the effective date of the IFC, CMS will require long-term care facilities to electronically report information about COVID-19 in a standardized format specified by the Secretary and no less than weekly to the CDC's National Healthcare Safety Network.

### **Scope of Practice**

- CMS will permit a physical therapist or occupational therapist who establishes a maintenance program to delegate the performance of the maintenance therapy services to a physical therapy assistant or occupational therapy assistant when clinically appropriate.
- Any individual who has a separately enumerated benefit under Medicare law to furnish and bill for services, whether or not they are acting in a teaching role, may review and verify (sign and date) notes in the medical record made by physicians, residents, nurses and students (including students in therapy or other clinical disciplines), or other members of the medical team.
- CMS clarified that pharmacists fall within the regulatory definition of auxiliary personnel and may provide services incident to the services of the billing physician or NPP, so long as payment is not made under the Part D benefit and appropriate supervision is provided.

### **Application of Certain National Coverage Determination (NCD) and Local Coverage Determination (LCD) Requirements During the PHE for the COVID-19 Pandemic**

- CMS reiterated that physicians, practitioners, and suppliers are required to continue documenting the medical necessity for all services.
- CMS will not enforce the clinical indications for therapeutic continuous glucose monitors in LCDs for the duration of the PHE.

### **What's Next?**

Although these policies are generally already in effect due to the public health emergency, Vizient will submit comments, due July 2020, on behalf of our members. Please do not hesitate to reach out with feedback on these policies – either in support of policies you may wish to see extended, or expressing any concern. Please direct your feedback to [Jenna Stern](#), Sr. Regulatory Affairs and Public Policy Director in Vizient's Washington, D.C. office, by June 22.