Vizient Office of Public Policy and Government Relations

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (Interim final rule with comment period)

April 7, 2020

Background and Summary

In response to COVID-19 and the additional authority granted to the Department of Health and Human Services (HHS) based on the Public Health Emergency (PHE) (under section 319 of the Public Health Service Act) and Coronavirus Preparedness and Responses Supplemental Appropriations Act, 2020 (P.L. 116-126), the Centers for Medicare and Medicaid (CMS) is immediately implementing several new policies via an interim final rule with comment period (IFC). CMS is changing several Medicare payment rules to expand access to care, particularly telehealth and communication technology-based services, address certain supervision-related barriers, and revise and clarify the agency's perspective regarding different payment model and programs (e.g., Medicare Shared Savings Program, Quality Payment Program, innovation center models and the Merit-based Incentive Payment System (MIPS)).

Generally, the flexibilities provided in the IFC are temporary and would last the length of PHE and any possible subsequent extensions. CMS has also provided a hospital-specific fact sheet outlining the recently provided flexibilities, including those related to waivers, several of which are not addressed in this IFC.

The IFC was published on April 6, 2020. However, CMS clarifies the new flexibilities are applicable retroactively, beginning on March 1, 2020. Comments are accepted until June 1, 2020.

Telehealth and Communication Technology-Based Services

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

- The IFC (read in conjunction with prior regulatory activity) specifies conditions that must be met for Medicare to reimburse telehealth services under the Physician Fee Schedule (PFS) and adds services to the list of telehealth services.
- New flexibilities:
    - Site-of-service differential for Medicare Telehealth services:
        - Unlike current practice, CMS will assign the payment rate that ordinarily would have been paid under the PFS were the services furnished in-person (e.g., at the non-facility or office rate).
        - How to bill: Physicians and practitioners who bill for Medicare telehealth services should report the point-of-service (POS) code that would have been reported had the service been furnished in person.
        - Telehealth modifier: The CPT telehealth modifier (modifier 95) should be applied to claim lines that describe services furnished via telehealth.

        - CMS is maintaining the facility payment rates for services using the general telehealth POS code 02, should practitioner choose to maintain their current billing practices for Medicare telehealth during the PHE.
    - Adding services (e.g., emergency department visits) to the list of Medicare Telehealth Services.
        - Starting with dates of service beginning March 1, 2020.
        - See Appendix 1 for a list of these services and CPT codes.

Telehealth Modalities and Cost-sharing

- CMS clarifies the telehealth technology requirements to provide more options to providers. Notably, CMS specifies the equipment must 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 would allow for the use of phones that include audio and video real-time interactive capabilities.
    - CMS noted the HHS Office for Civil Rights is exercising enforcement discretion and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies (e.g., FaceTime, Skype) for the PHE.
- Beneficiary cost-sharing:
    - The IFC indicates OIG's Policy Statement on cost-sharing applies to a broad category of non-face-to-face services furnished through various modalities (e.g., telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring) in addition to telehealth services (§410.78).
    - The Policy Statement also applies when the physician or practitioner has reassigned his or her right to receive payment to hospitals or other eligible individual or entities billing on their behalf.

Telephone Evaluation and Management (E/M) Services

- CMS is now covering prolonged, audio-only communication between the practitioner and the patient (including new patients), even though CMS maintains these services do not fully replace a face-to-face visit.
- CMS is finalizing separate payment for CPT codes 98966-98968 (work RVUs 0.25-0.75) (telephone assessment and management service by a qualified nonphysician health care professional) and CPT code 99441-99443 (work RVUs 0.25 – 0.75) (telephone E/M services by a physician or other qualified health care professional)
    - CMS will not conduct reviews to consider whether these services were furnished to established patients.
- CMS clarified CPT codes 98966-98968 may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service provided by that practitioner.

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

- CMS specified 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.
- CMS also removes requirements regarding documentation of history and/or physical exam in the medical record but expects that practitioners will document E/M visits as necessary to ensure quality and continuity of care.

Communication Technology-Based Services (CTBS)

- Background: CTBS services (e.g., remote physiologic monitoring and remote interpretation of diagnostic tests) are routinely furnished using a telecommunications system but are not considered telehealth services.
- Under the IFC, CMS provides additional flexibility regarding consent requirements, indicates CTBS services can be furnished to new and established patients and adds flexibility for practitioner billing.
    - CMS is exercising enforcement discretion and will not conduct reviews to consider whether those services were furnished to established patients (CPT codes 99421, 99422, and 99423 and HCPCS codes G2061, G2062 and G2063).
    - Practitioner billing:
        - Online assessment can be billed by several practitioners (e.g., clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services) (HCPCS codes G2061 – G2063).
        - CMS is broadening the availability of remote evaluation of patient image/video and virtual check-in (HCPCS codes G2010 and G2012) to include services provided by licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.
            - CMS seeks input on other kinds of practitioners who might furnish these kinds of services in the context of the PHE.
            - CMS is permitting private practice occupational therapists, physical therapists, and speech-language pathologists billing CTBS “sometimes therapy” services (HCPCS codes G2010, G2012, G2061, G2062, or G2063) but they must include the corresponding therapy modifier (e.g., GO, GP or GN) on claims.
    - CMS is retaining the requirement that when the brief CTBS originates from a related E/M (even one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, that this service would be considered bundled into that previous E/M service and would not be separately billable.
- CMS is allowing remote physiologic monitoring (RPM) services to be furnished to new and established patients and easing consent requirements.

    - RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions, in addition to other conditions (e.g., monitoring pulse and oxygen saturation levels in a patient with an acute respiratory virus).

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

- CMS is expanding the services that can be included in the payment for virtual communication services (i.e., communication-based technology or remote evaluation of recorded video and/or images) between an RHC or FQHC practitioner and a patient (HCPCS code G0071), updating the payment rate, waiving the face-to-face requirement and clarifying consent requirements.
    - CMS is adding the CPT codes (99421 – 99423) to allow for longer visits.
    - Payment rates for code G0071 will be the average of the PFS national non-facility payment rates for HCPCS codes G2012, HCPCS G2010, CPT code 99421, CPT code 99422 and CPT code 99423.
    - Services payable using HCPCS code G0071 are now available to new patients.
- CMS is easing the home health agency shortage area requirement for furnishing visiting nursing services.

Supervision-Related Flexibilities

- Relying on individual practitioners' judgment, CMS revises the definition of direct supervision to allow direct supervision to be provided using real-time interactive audio and video technology (interactive telecommunications technology) when needed to reduce exposure risks for the patient or health care provider.
    - This does not change underlying payment or coverage policies related to Medicare benefits, including Part B drugs.
    - The IFC provides examples of scenarios where this change may be utilized (e.g., incident to services by a nurse or other auxiliary personnel; infused or injected Part B drugs administered at home with supervision via interactive telecommunications technology).
- CMS is relaxing the teaching physician regulations (§415.172) to allow a teaching physician to provide supervision either with physical presence or through interactive telecommunications technology during the key portion of the service.
    - Telecommunications technology flexibilities do not apply for:
        - Surgical, high-risk, or other complex procedures or
        - Anesthesia services.
    - CMS is similarly relaxing requirements under the "Primary Care Exception" (§415.174) to allow any level of E&M service to be performed by a resident if the teaching physician is available through interactive telecommunications technology.
    - CMS also provides flexibility for residents to provide telehealth services where the teaching physician may bill for the services if they were present for key portions of the service through interactive telecommunication technology.

- For outpatient hospital therapeutic services assigned to the non-surgical extended duration therapeutic services (NSEDTS), CMS is permitting a minimum level of general supervision; this would be consistent with the minimum default level of general supervision that applies for most outpatient hospital therapeutic services.

Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During the Public Health Emergency (PHE) for the COVID-19 Pandemic

- CMS is changing their current policy that prohibits routine services (e.g., bed, board, nursing and other related services) from being provided under arrangement outside the hospital.
- Under the new temporary policy, hospitals are allowed broader flexibility to furnish inpatient services, including routine services, under arrangements outside the hospital.
- CMS is not changing their policy that a hospital needs to exercise sufficient control and responsibility over the use of hospital resources in treating patients (regardless of whether treatment occurs in the hospital or outside the hospital under arrangements).

Origin and Destination Requirements Under the Ambulance Fee Schedule

- CMS will expand the list of destinations for which Medicare covers ambulance transportation to include all destinations, from any point of origin, that are equipped to treat the condition of the patient consistent with state/local Emergency Medical Services (EMS) protocols where the service will be furnished.
    - Expanded destinations includes: any location that is an alternative site determined to be part of a hospital, critical access hospital (CAH) or skilled nursing facility (SNF), community mental health centers, federally qualified health centers (FQHCs), rural health clinic (RHCs), physicians' offices, urgent care facilities, ambulatory surgery centers (ASCs), any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available, and the beneficiary's home.

Medicare Clinical Laboratory Fee Schedule: Payment for Specimen Collection for Purposes of COVID-19 Testing

- During the PHE, Medicare payment policies are changing to provide payment to independent laboratories for specimen collection for COVID-19 testing under certain conditions.
- Specimen collection fee policy changes: Medicare will pay for a nominal specimen collection fee (generally, $23.46 for individuals in a SNF and $25.46 for laboratory samples collected on behalf of a home health agency (HHA)) and associated travel allowance to independent laboratories for collection of specimens related to COVID-19 clinical diagnostic laboratory testing for homebound and non-hospital inpatients.

Innovation Center Models

Medicare Diabetes Prevention Program (MDPP)

- CMS is permitting certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increasing the number of virtual make-up sessions, and allowing certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis.
- CMS aims to prioritize availability and continuity of services for MDPP suppliers (enrolled as of March 1, 2020) and MDPP beneficiaries (those receiving services as of March 1, 2020) impacted by extreme and uncontrollable circumstances during the PHE.
- CMS referenced CDC guidance to MDPP suppliers on March 12, 2020 on providing alternative delivery options during the national emergency; CMS intends to conform with the CDC guidance and CDC Diabetes Prevention Recognition Program (DPRP) standards, where feasible, to minimize disruption of services.

Comprehensive Care Joint Replacement (CJR) Model

- CMS is implementing the following changes to the CJR model:
    - A 3-month extension to CJR performance year (PY) 5; the model will now end on March 31, 2021. CMS wants to ensure continuity of the CJR model operation in participant hospitals during the PHE and referenced the CJR Proposed Rule to extend the model by 3 years (85 FR 10516).
    - Expanding the current CJR extreme and uncontrollable circumstances policy such that it will be applicable to episodes impacted by the COVID-19 pandemic. CMS indicated all participant hospitals qualify for applicable financial safeguards during the emergency period and will not be held financially liable for escalating episode costs that escalate due to the effects of COVID-19.
    - CMS is applying equal financial safeguards for fracture and non-fracture episodes during the PHE (which is different from the safeguards associated with a major disaster declaration).

Alternative Payment Model (APM) treatment under the Quality Payment Program (QPP)

- CMS will consider additional rulemaking, including possibly another interim final rule, to amend or suspend APM QPP policies as necessary.

Change to the Medicare Shared Savings Program (MSSP) Extreme and Uncontrollable Circumstances Policy (2019 Performance Year/2020 Payment Year)

- 2019 data submission deadline extended by 30 days until April 30, 2020.
- CMS changed the MSSP extreme and uncontrollable circumstance policy so all MSSP ACOs that may be unable to report quality data for 2019 are covered.
- MIPS eligible clinicians who are subject to the APM scoring standard (e.g., MIPS eligible clinicians participating in the Shared Saving Program ACOs), will continue to be scored under the existing APM scoring standard.

    - If no eligible clinicians in an APM entity submit data by the extended deadline for the Quality and Promoting Interoperability performance categories due to extreme and uncontrollable circumstances then:
        - Cost performance category: 0% weight (as usual)
        - Improvement Activities performance category: scored as usual
        - Quality performance category = reweighted to 0% if APM waived quality report in certain circumstances
        - Promoting Interoperability performance category: If all MIPS eligible clinicians in APM entity excepted from reporting Promoting Interoperability performance category, then it will be reweighted to 0% for the APM for that MIPS performance period
        - Improvement performance category = scored
        - If one performance category scored there will be a neutral MIPS adjustment
- Future changes would need to occur via notice and comment rulemaking.
- PY 2020 Shared Savings Program financial reconciliations: CMS will reduce the amount of an ACO's shared losses by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an affected area.
- Shared Savings Program update to the ACO's benchmark: the factors used to update the ACOs' benchmarks will reflect the national and regional trends related to spending and utilization changes during 2020, including changes related to the PHE.

Merit-based Incentive Payment System Updates (2019 Performance Year / 2020 Payment Year)

- 2019 data submission deadline extended until April 30, 2020.
    - Late data submissions will override previous data submissions.
- CMS adds one new high-weighted improvement activity (clinicians must report their findings through an open source clinical data repository or clinical data registry) to the Improvement Activities Inventory for the CY 2020 performance year.
- CMS is extending the MIPS extreme and uncontrollable circumstance application to allow clinicians adversely affected by the COVID-19 public health emergency to submit an application and request the MIPS performance categories be reweighted and potentially receive a neutral MIPS payment adjustment for the 2021 payment year. MIPS eligible clinicians do not need to take additional action to qualify for the automatic extreme and uncontrollable circumstances policy.
    - Under the extreme and uncontrollable circumstance policy:
        - If no data is submitted all performance categories will be reweighted to zero percent, leading to a neutral payment adjustment for the 2021 MIPS payment year.
        - If data on two or more performance categories are submitted, they will be scored and receive a 2021 MIPS payment adjustment based on their 2019 MIPS final score.

- MIPS eligible clinicians subject to the APM scoring standard will not be directly affected by the MIPS automatic and extreme uncontrollable circumstance policy (see MSSP extreme and uncontrollable circumstances policy above for more information).

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

- To the extent an NCD or LCD (including articles) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements would not apply during the PHE.
    - This does not change clinical indications of coverage for any LCD or NCD unless specifically indicated by CMS.
- CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs.

What's Next?

Although these policies are already in effect due to the public health emergency, Vizient will submit comments, due June 1, 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 May 22.

Appendix 1:

Category	CPT Codes
Emergency department visits	99281 - 99285
Initial and subsequent observation, and observation discharge day management	99217 - 99220 99224 - 99226 99234 – 99236
Inpatient hospital care and hospital discharge date management	99221 - 99223 99238 99304 - 99306 99315 - 99316
Critical care services	99291 - 99292
Domiciliary, Rest Home, or Custodial Care Services: CPT Codes	99327 - 99328 99334 - 99337
Home visits	99341 - 99350
Inpatient neonatal and pediatric critical care	99468 - 99469 99471 - 99476
Initial and continuing intensive care services	99477 - 99480
Care Planning for Patient with Cognitive Impairment	99483
Group Psychotherapy	90853
ESRD Services	90952 - 90953 90959 90962
Psychological and Neuropsychological Testing:	96130 - 96133 96136 - 96139
Therapy Services *Note:* CMS did not add services furnished by physical therapists, occupational therapists and speech-language pathologists to the list of telehealth services	97161 - 97168 97110 97112 97116 97535 97750 97755 97760 - 97761 92521 – 92524 92507
Radiation treatment management services: CPT code	77427