On March 30th, CMS released the interim final rule with comment period on *Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency*. The purpose of the rule is to “change Medicare payment rules during the public health emergency for the COVID-19 pandemic so that [health care entities] are allowed broad flexibilities to furnish services using remote communications technology to avoid exposure risks to health care providers, patients, and the community.”

Unlike other interim final rules, there was no preceding proposed rule for this interim final rule, which is typically required by the Administrative Procedure Act (APA). However, CMS argues that the exigent circumstances presented by the COVID-19 outbreak and the declared public health emergency (PHE) provide the agency good cause to support a jump directly to the interim final rule and an interim effective date starting March 1, 2020. CMS will still collect comments on the changes included in the rule, which are due 60 days from the publication date of the rule.

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

**Proposed Changes**

- **Place of Service and Modifier Billing Guidance:**
  CMS is instructing physicians and other clinicians billing for Medicare telehealth services to submit their claims using the Place of Service (POS) code that they would have reported had the service been furnished in person, and with Modifier -95 to indicate that the service was furnished via telehealth. This will allow CMS to reimburse services at the same rate as if they were furnished in person. Claims submitted using POS code 2 will continue to be reimbursed under the facility payment rate (discussed below).

- **Additional Telehealth Services:**
  CMS is expanding the list of services that can be furnished via telehealth for the duration of the COVID-19 PHE. The expanded list includes the following: 1) Emergency Department Visits; 2) Initial and Subsequent Observation, and Observation Discharge Day Management; 3) Initial hospital care and hospital discharge day management; 4) Initial nursing facility visits and nursing facility discharge day management; 5) Critical Care Services; 6) Domiciliary, Rest Home, or Custodial Services; 7) Home Visits; 8) Inpatient Neonatal and Pediatric Critical Care; 9) Initial and Continuing Intensive Care Services; 10) Care Planning for Patients with Cognitive Impairment; 11) Group Psychotherapy; 12) End-Stage Renal Disease Services (ESRD); 13) Psychological and Neuropsychological Testing; 14) Therapy Services; and 15) Radiation Treatment Management Services.

**Background/Rationale**

- **Place of Service and Modifier Billing Guidance:**
  Under the Medicare Physician Fee Schedule (MPFS), telehealth services are reimbursed either at the facility rate, non-facility, or office rate. The facility rate is paid based on and to the originating site (where the patient is located), rather than the distant site (where the physician is located); and a facility rate is only paid when the originating site is a permissible site under Section 1834(m). For telehealth services, the originating site facility fee is a nationally applicable flat fee, paid without any adjustments. Per recent guidance, CMS was requesting clinicians to submit telehealth claims using POS code 2, which was reimbursed at the flat facility payment rate.

  Recognizing that practices’ costs for furnishing telehealth services during the PHE may not significantly differ (since practices are still employing staff and incurring other costs), CMS believes that the payment should reflect the rate that would have been paid as if the services were furnished in person.

- **Additional Telehealth Services:**
  To date, CMS was only reimbursing for services that were finalized in previous years for telehealth reimbursement under the MPFS, which included, among other services, Office/Outpatient, Transitional Care Management, Advance Care Planning, and Annual Wellness Visits services.

**Comments:** CMS is requesting feedback on potential negative consequences of adding the additional CPT codes to list of telehealth services.
B. Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations and Required “Hands-on” Visits for ESRD Monthly Capitation Payments

Proposed Changes

Given the exigent circumstances of the COVID-19 emergency, CMS does not believe that certain frequency limitations of the new services added to the telehealth service are appropriate or necessary.

- Waiver of frequency requirements for certain codes

On an interim basis, CMS is removing the frequency restrictions for each of the following codes for the duration of the PHE. CMS is also removing the restriction that critical care consultation codes may only be furnished once per day.

1. Subsequent Inpatient Visits. CPT codes 99231-99233 (subsequent hospital care, per day, for the evaluation and management of a patient)
2. Subsequent Nursing Facility Visits. CPT codes 99307-99310 (subsequent nursing facility care, per day, for the evaluation and management of a patient)
3. Critical Care Consultation Services. HCPCS codes G0508 and G0509 (telehealth consultation, critical care, initial and subsequent)

- Waiver of ESRD “Face-to Face” Telehealth Requirements

CMS is also waiving certain “face-to-face” requirements for ESRD-related telehealth services. Specifically, CMS is waiving the requirement of an in-person clinical examination of the vascular site from existing ESRD telehealth services for the duration of the PHE.

Furthermore, CMS is waiving the face-to-face requirements of the following ESRD telehealth CPT codes:

- 90951-90955 (ESRD related services monthly, for patient age ranges)
  - NOTE: 90956 is NOT included, whether by purposeful or accidental omission
- 90957-90962 (ESRD related services monthly, for patient age ranges)
- 90963-90966 (ESRD related services for home dialysis per full month, for patient age ranges)
- 90967-90970 (ESRD related services for dialysis less than a full month of service, for patient age ranges)

Background/Rationale

Generally, CMS evaluates any new telehealth service to assess an appropriate maximum frequency of services/visits per service type. Part of CMS’ general concern is to make sure that telehealth services do not supplant necessary in-person services. In the context of this PHE, CMS feels that telehealth’s ability to mitigate exposure risk may reflect the most appropriate care.
C. Telehealth Modalities and Cost-Sharing

Proposed Changes

• Modalities

CMS is adding an exception to the definition of interactive telecommunications systems for Medicare telehealth services so that, for the duration of the COVID-19 PHE, interactive telecommunications system includes “multimedia communications equipment that includes, at a minimum, audio and visual equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.”

CMS also reemphasized that the HHS Office for Civil Rights (OCR) is exercising enforcement discretion and waiving HIPAA violation penalties for good faith provision of telehealth services during the COVID-19 PHE; however, HHS, Office of the Inspector General (OIG), and Department of Justice (DOJ) will actively monitor for fraud and abuse, and potential Medicare COVID-19 scams.

• Cost-Sharing

CMS clarifies that OIG’s recent Policy Statement, which notifies clinicians that they will not be subject to administrative sanctions for reducing or waiving beneficiary cost-sharing obligations, applied broadly to non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-ins, monthly remote care management, monthly remote patient monitoring, etc.

Background/Rationale

• Modalities

The current regulations state that telephones, facsimile machines, and electronic mail systems do not meet the definition of interactive telecommunications systems for Medicare telehealth services.

D. Communication Technology-Based Services (CTBS)

Proposed Changes

• Virtual Check-Ins

CMS is allowing CTBS, HCPCS codes G2010 (remote evaluation of recorded video and/or images submitted by an established patient) and G2012 (5-10 mins CTBS check-in for an established patient) to be furnished to both new and established patients, and is clarifying that consent can for these services can be obtained at the same time that a service is furnished and that it can be obtained and documented by auxiliary staff under general supervision as well as by the billing clinician. CMS is also permitting these codes to be billed by licensed clinical social workers (LCSWs), clinical psychologist (CPs), physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs).

• Online Digital Services

For CPT codes 99421-99423 (online digital E/M services for established patients) and HCPCS codes G2061-G2063 (qualified nonphysician qualified healthcare professional online assessment and
management services for established patients), CMS is exercising enforcement discretion for the “established patient” requirement.

- “Sometimes Therapy” Services

CMS is designating HCPCS codes G2010, G2012, and G2061-G2063 as “sometimes therapy” services, requiring private practice OTs, PTs, and SLPs to include their respective GO, GP, or GN therapy modifier on claims. These would be for new and established patients.

**Background/Rationale**

CTBS are those services furnished via telecommunications technology but are not considered Medicare telehealth services; commonly referred to as “virtual check-ins.” These services are limited to established patients, can only be billed by physicians and other clinicians who can furnish E/M services, and require annual beneficiary consent. CMS is providing flexibilities for these services so they can be available to a larger Medicare beneficiary population and help mitigate exposure risk for vulnerable patients.

CMS is retaining the requirement that when CTBS originate from related E/M services (including telehealth E/M services) within the previous 7 days by the same physician or other qualified health care professional, it is bundled into the previous E/M service and cannot be billed for separately.

Additionally, CMS clarified that HCPCS codes G2061-G2063 can be furnished and billed for by LCSWs, CPs, PTs, OTs, and SLPs.

**Comments Requested:** CMS is seeking input on other kinds of practitioners who might be furnishing CTBS during the COVID-19 PHE.

### E. Direct Supervision by Interactive Telecommunications Technology

**Proposed Changes**

CMS is allowing the direct supervision requirement to be met using real-time audio and video technology during the COVID-19 PHE. Note, CMS is not changing the underlying payment or coverage policies related to scope of Medicare benefits, including Part B drugs, and is not changing the actual supervision requirements for services. Physicians can enter into contractual arrangements with auxiliary personnel to leverage additional staff and technology necessary to provide such services.

CMS is extending these flexibilities to supervision of diagnostic services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient hospital department, as well as to pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services.

**Background/Rationale**

In many cases, the physician or non-physician practitioner (NPP) must be in a specific location, usually in the same vicinity as the beneficiary, to meet the supervisions requirements for different services. CMS recognizes that it may be difficult to physically meet the supervision requirements during the COVID-19 PHE in certain cases, including when the billing physician and/or the patient may need to be isolated or their physical proximity limited. CMS believes clinicians are in the best position to make informed clinical
decisions on when telehealth can be used to meet the supervision requirements to reduce exposure risks for the beneficiary or health care provider.

CMS noted that it will be monitoring claims to ensure that services are not inappropriately being unbundled from Home Health Prospective Payment System (PPS) payments.

Comments Requested: CMS is seeking feedback on whether any guardrails are necessary and what kinds of risks could increase for beneficiaries under this policy

F. Clarification of Homebound Status under the Medicare Home Health Benefit

Proposed Change

For the purposes of beneficiaries meeting the requirement to be “confined to home” (also referred to as “homebound”) as a perquisite to receiving home health services, CMS clarifies that the definition of “confined to the home” allows patients to be considered such if it is medically contraindicated for the patient to leave the home.

This clarification is not limited to the COVID-19 PHE; however, in the context of the COVID-19, this would apply for those patients: 1) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because they have a confirmed or suspected diagnosis of COVID-19; or 2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19. A patient who is exercising “self-quarantine” for one’s own safety would not be considered “confined to the home” unless a physician certifies that it is medically contraindicated for the patient to leave the home.

In cases where it is medically contraindicated for the patient to leave the home, the medical record documentation for the patient must include information as to why the individual condition of the patient is such that leaving the home is medically contraindicated.

Background/Rationale

To receive home health services, beneficiaries must: 1) be confined to the home, 2) need skilled services, 3) be under the care of a physician, 4) receive services under a plan of care from a physician, and 5) have had a face-to-face encounter with a certified clinician.

With respect to the homebound condition, there are two criteria that beneficiaries must both satisfy in order to meet the requirement: 1) the individual must have a condition such that leaving their home is medically contraindicated or because of illness or injury, needs, the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence; and 2) there must exist a “normal inability” to leave home and leaving home must require a considerable and taxing effort.

Comments: CMS seeks comment on this clarification.
G. The Use of Telecommunications Technology Under the Medicare Home Health Benefit During the PHE for the COVID-19 Pandemic

**Proposed Changes**

For the duration of the COVID-19 PHE, CMS is amending home health regulations to provide home health agencies (HHAs) with the flexibility to use various types of telecommunications systems in conjunction with the provision of in-person home health visits. CMS is specifically allowing the use of technology related to the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit or when there is a home visit.

Additionally, the use of technology must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care. However, as under current regulation and as prohibited by statute, these services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment.

Notably, HHAs can report the costs of telecommunications technology as allowable A&G costs on an interim basis.

**Background/Rationale**

Before this interim change, remote patient monitoring systems were the only form of telecommunications systems eligible to be included in a care plan and could be included as an allowed administrative expense. This interim change implements a broader definition for the types of services that are allowable to be used to support home health services. CMS remains statutorily prohibited from paying for home health services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care. However, HHAs are free to use telecommunications systems, as long as such services do not: 1) substitute for in-person home health services ordered as part of a plan of care certified by a physician; and 2) are not considered a home health visit for purposes of eligibility or payment.

**Comments:** CMS seeks feedback on these interim changes

H. The Use of Technology Under the Medicare Hospice Benefit

**Proposed Changes**

For the duration of the COVID-19 PHE, hospices may provide services via a telecommunications system when a patient is receiving routine home care if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patient’s terminal illness and related conditions without jeopardizing the patient’s health or the health of those who are providing such services. The use of such technology must be included on the plan of care.

However, there is still no payment beyond the per diem amount for the use of technology in providing services under the hospice benefit. For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can
report the costs of telecommunications technology used to furnish services under the routine home care level of care during COVID-19 PHE as “other patient care services” using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE for COVID-19.”

**Background/Rationale**

CMS hopes this interim amendment will help to increase access to technologies, such as telemedicine and remote patient monitoring, that enable the necessary flexibility for patients to be able to receive necessary services without jeopardizing their health or the health of those who are providing those services during the COVID-19 PHE.

**Comments:** CMS seeks comments on these interim changes

**I. Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement**

**Proposed Changes**

During the PHE, a face-to-face encounter conducted by a hospice physician or hospice nurse practitioner (NP) for the sole purpose of hospice recertification, may occur via telehealth.

**Background/Rationale**

Telehealth technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice NP.

**J. Modification of the Inpatient Rehabilitation Facility (IRF) Face-to-Face Requirement for the PHE During the COVID-19 Pandemic**

**Proposed Change**

CMS is proposing to allow the face-to-face visit requirements at §§ 412.622(a)(3)(iv) and 412.29(e) to be conducted via telehealth to safeguard the health and safety of Medicare beneficiaries and the rehabilitation physicians treating them.

**Background/Rationale**

For an inpatient rehabilitation facility (IRF) claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient’s admission to the IRF that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF to assess the patient both medically and functionally, as well as modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process.
K. Removal of the IRF Post-Admission Physician Evaluation Requirement for the PHE for the COVID-19 Pandemic and Clarification Regarding the “3-Hour” Rule

Proposed Changes

- **Documentation Requirement:**
  For the duration of the COVID-19 PHE, CMS is waiving the post-admission physician evaluation IRF payment requirement.

- **3-Hour Rule:**
  CMS clarifies that in cases where IRF’s intensive rehabilitation therapy program is impacted by the COVID-19 PHE, the IRF should document this in the medical record and is not obligated to meet the industry standards.

Background/Rationale

- **Documentation Requirement:**
  To receive payments, IRFs patient medical records must contain a post-admission physician evaluation that meets the following three requirements: 1) is completed by the rehabilitation physician within 24 hours of the patient’s IRF admission; 2) documents the patient’s status upon IRF admission, including a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care; **AND** 3) is retained in the patient’s medical record at the IRF. CMS wants to reduce the amount of time IRF physicians spend completing paperwork and instead focus on caring for patients and helping where they may be needed during the COVID-19 PHE.

- **3-Hour Rule:**
  IRF-level of care generally requires that a beneficiary is expected to participate in and benefit from an intensive rehabilitation therapy program that generally consists of at least 3 hours of therapy per day at least 5 days per week. However, CMS recognizes this requirement may be difficult to meet due to staffing shifts and disruptions.

Comments: CMS invites feedback on this proposal.

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

Proposed Changes

CMS is expanding the use and reimbursement for virtual communication and evaluation services provided by rural health clinic (RHC) and federally-qualified health center (FQHC) practitioners. Specifically, this rule expands the services billable under HCPCS code G0071 (which originally represents 5 minutes or more of (1) virtual (non-face-to-face) communication between a RHC/FQHC practitioner and patient, or (2) remote evaluation of recorded video and/or images by an RHC/FQHC practitioner in lieu of an office visit) to include online digital E/M services (CPT codes 99421, 99422, and 99423—depending on total time
spent, respectively). Furthermore, CMS is waiving face-to-face requirements for such services, as well as requirements that the beneficiary has been seen by an RHC/FQHC practitioner during the previous 12 months (therefore, deeming such services available to new patients).

CMS is also looking to expand the reach of visiting nurse services provided by RHCs and FQHCs, by deeming all RHC and FQHC service areas as having a shortage of home health agencies (HHAs) (therefore allowing the reimbursement of visiting nurse services by RHCs/FQHCs regardless if such areas contain HHAs). However, such services will not be covered by Medicare if they overlap with a 30-day period of home health care already provided to the patient. Furthermore, CMS is revising the definition of “homebound” to match the definition outlined in this interim final rule, as it pertains to the COVID-19 PHE.

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

Proposed Changes

CMS is creating a separate nominal specimen collection fee and associated travel allowance for independent laboratories collecting specimens related to COVID-19 clinical diagnostic laboratory testing for homebound and non-hospital inpatients. The specimen collection fee will be valued at $23.46 ($25.46 for individuals in a SNF or individuals whose samples are collected by a lab on behalf of an HHA). CMS also clarifies that the use of NP or OP swabs, or collection of sputum, are actions that require a trained laboratory professional, and therefore satisfy service requirements to bill for such fees. Independent labs must use the following codes:

- G2023: Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)
- G2024: Specimen collection for SARS-CoV-2 from an individual in a SNF or on behalf of a HHA

Labs will also be able to accept travel allowances. However, the billing and coding structure for this remains the same – labs will use the existing HCPCS codes P9603 and P9604, respectively. Notably, CMS clarifies that independent labs will not have to maintain paper documentation of miles traveled (but will be responsible for maintaining electronic logs for MACs to review).

Furthermore, CMS is aligning the “homebound” requirement for service fees and testing to align with the new and temporary definition of “homebound” provided in this interim final rule.

Background/Rationale

Specimen collection fees are provided to cover the transportation and personnel expenses associated with the collection of specimens from homebound patients and inpatients (not in a hospital), in addition to the amounts provided for under the Medicare Clinical Laboratory Fee Schedule. CMS believes that increasing the fee amount, as well as sustaining flexibilities in “homebound” designation (relayed throughout this final rule), will improve the provision of independent lab COVID-19 diagnostics in the home setting.
N. Requirements for Opioid Treatment Programs (OTP)

Proposed Change

For the duration of the PHE, CMS is revising 410.67(b)(3) and (4) to allow the therapy and counseling portions of the weekly bundle of services furnished by OTPs, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication if a beneficiary does not have access to such two-way communication options.

Background/Rationale

In the 2020 MPFS Rule, CMS finalized the use of interactive two-way audio/video communication for services furnished by OTPs. CMS believes this change is necessary to ensure that beneficiaries with opioid use disorder are able to continue to receive these important services during the PHE.

O. Application of Teaching Physician and Moonlighting Regulations during the PHE for the COVID-19 pandemic During the PHE for COVID-19

Proposed Change

- Revisions to Teaching Physician Regulations during a PHE for the COVID-19 Pandemic

For the duration of the COVID-19 PHE, CMS is amending the teaching physician regulations to allow that as a general rule under § 415.172, the requirement of direct supervision from a teaching physician can be met, at a minimum, through interactive telecommunications technology.

CMS states that teaching physicians can supervise residents via telehealth for specific instances. This includes instances when residents are involved in psychiatric service and all service levels of an office/outpatient E/M service provided in primary care centers.

CMS will also allow a MPFS payment to be made for the interpretation of diagnostic radiology and other diagnostic tests when the interpretation is performed by a resident under direct supervision of the teaching physician by interactive telecommunications technology. The teaching physician must still review the resident’s interpretation.

CMS also outlines instances when a teaching physician must be physically present, such as cases of surgical, high-risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

- Application of the Expansion of Telehealth Services to Teaching Physician Services

This section clarifies the Medicare expansion of telehealth services pursuant to waiver authority added under section 1135(b)(8) by the Coronavirus Preparedness and Response Supplemental Appropriations Act as it related to teaching physician services, including those furnished under the primary care exception. CMS states that Medicare may make payment under the MPFS for teaching physician services when a resident furnishes telehealth services to beneficiaries under a teaching physician’s direct supervision via interactive telecommunications technology, including when services are provided under the primary care exception.
Payment under the MPFS for Teaching Physician Services when Resident under Quarantine

In corroboration with the changes made in section O subsection b., Medicare may also make payment under the MPFS for teaching physician services when the resident is providing services while in quarantine and under direct supervision of a teaching physician by interactive telecommunications technology.

Revisions to Moonlighting Regulations during the COVID-19 PHE

CMS is amending § 415.208 to state that the services of residents are separately billable physicians’ services that can be paid under the PFS if the services are: 1) not related to their approved GME programs and 2) performed in the inpatient setting of a hospital in which they have their training program. This is based on the conditions that: 1) the services are identifiable physicians’ services and meet the conditions of payment for physicians’ services per 415.102(a); 2) the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the state in which the services are performed; and 3) the services are not performed as part of the approved GME program.

Background/Rationale

In context of the COVID-19 PHE, stakeholders have asked CMS to loosen supervision requirements for teaching physician services under the MPFS. Amending the supervision requirements to include supervision via telecommunications and resident services via telehealth is necessary to protect patients and providers from COVID-19 and expands the number of qualified practitioners to meet the increased demand for care. Under normal circumstances, section 1842(b) of the Act specifies the Secretary shall not provide payment for physicians’ services provided to a patient in a hospital with a teaching program unless the teaching physician renders sufficient services to the patient to exercise control over the management of the portion of the case for which payment is sought.

Comments:

Revisions to Teaching Physician Regulations during the COVID-19 PHE

CMS seeks comment on whether other procedures (in addition to surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services) should also be exempt from this policy given the complex nature or potential danger to the patient.

CMS also seeks comment on their reasoning that direct supervision by interactive telecommunications technology is appropriate in the context of this PHE, as well as whether any guardrails should be included, and how it balances risks that might be introduced for beneficiaries with reducing exposure risk and the increased spread of the disease, in the context of this PHE.

Application of the Expansion of Telehealth Services to Teaching Physician Services

In this section CMS is seeking comment on their reasoning that direct supervision by interactive telecommunications technology is appropriate in the context of this PHE, as well as whether and how it balances risks that might be introduced for beneficiaries with reducing exposure risk and the increased spread of the disease, in the context of this PHE.
P. Special Requirements for Psychiatric Hospitals

Proposed Change

NOTE: this change is not related to COVID-19 or CMS’ response to the outbreak. In the interest of an ongoing effort to allow advanced practice practitioners to practice to the full scope of their license, CMS is allowing a range of practitioners to record progress notes instead of the more specific list in §482.12(c). CMS is accomplishing this by removing the reference to §482.12(c) from the current provision in §482.61(d), which governs the recording of these notes.

Background/Rationale

Currently §482.12(c) states that the governing body of a hospital must ensure that every Medicare patient is under the care of one on a list of practitioners. In previous final rules, CMS has modified the applicability of the physician-specific practitioner list found there. This change is made to reflect CMS’ belief that advanced practice practitioners, subject to their state laws, should have the authority to practice more broadly and to the highest level of their education.

Q. Innovation Center Models

Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Proposed Changes

CMS makes the following interim changes to conform with CDC guidance for MDPP beneficiaries and suppliers:

- MDPP suppliers can either deliver MDPP services virtually or suspend in-person services and resume services at a later date;
- The limit to the number of virtual make-up sessions is waived for MDPP suppliers with existing capabilities to provide services virtually, as long as the virtual services are furnished in a manner that is consistent with the CDC standards for virtual sessions, follow the CDC-approved DPP curriculum requirements, and are provided upon the individual MDPP beneficiary’s request;
- MDPP suppliers may only furnish to the MDPP beneficiary a maximum of one session on the same day as a regularly scheduled session and a maximum of one virtual make-up session per week;
- Virtual make-up sessions may only be furnished to achieve attendance goals and may not be furnished to achieve weight-loss goal;
- MDPP suppliers may offer to an MDPP beneficiary no more than: 15 virtual make-up sessions offered weekly during the core session period; 6 virtual make-up sessions offered monthly during the core maintenance session interval periods; and 12 virtual make-up sessions offered monthly during the ongoing maintenance session interval periods; and
- Certain MDPP beneficiaries may obtain a set of MDPP services more than once per lifetime, for the limited purposes of allowing a pause in service and to provide the flexibilities that will allow MDPP beneficiaries to maintain eligibility for MDPP services despite a break in service, attendance, or weight loss achievement.
**Background/Rationale**

These changes are in response to interruptions in expanded model services delivered by MDPP suppliers and/or prevented MDPP beneficiaries from attending sessions.

**Changes to the Comprehensive Care for Joint Replacement (CJR) Model to Extend the Length of Performance Year 5 by Three Additional Months and to Change the Extreme and Uncontrollable Circumstances Policy to Account for the COVID-19 Pandemic**

**Proposed Changes**

CMS is implementing a 3-month extension of the fifth performance year for the CJR model.

Additionally, CMS is broadening its extreme and uncontrollable circumstances policy by applying certain financial safeguards to participant hospitals that have a CCN primary address that is located in an emergency area for episodes that overlap with the emergency period. Specifically, for a fracture or non-fracture episode with a date of admission to the anchor hospitalization that is on or within 30 days before the date of the beginning of the public health emergency period or that occurs through the termination of the emergency period, actual (i.e., incurred) episode payments are capped at the target price determined for that episode for the purposes of determining hospital performance.

**Background/Rationale**

CMS does not expect many new CJR episodes to initiate given guidance on the need to avoid elective surgeries considering the COVID-19 PHE. However, it recognizes that a number of beneficiaries are in active CJR episodes that initiated prior to March 2020 and CJR hip fracture episodes, which generally result from emergent accidents and are not necessarily avoidable, will continue to occur. To account for these instances while hospitals focus on treating COVID-19 cases, CMS is expanding its extreme and uncontrollable circumstances policy for the model.

**Alternative Payment Model Treatment Under the Quality Payment Program**

**Potential for Future Rulemaking**

CMS recognizes that its current regulations may be insufficient for purposes of adequately responding to the still-emerging COVID-19 national emergency and that additional action may be necessary and appropriate to prevent APM participants from facing undue burden in or negative consequences through the Quality Payment Program (QPP).

Therefore, CMS will consider undertaking additional rulemaking, including possibly another interim final rule, to amend or suspend APM QPP policies as necessary to ensure accurate and appropriate application of QPP policies in light of the COVID-19 PHE.
**R. Remote Physiologic Monitoring**

**Proposed Changes**

CMS is allowing providers, during this PHE, to furnish Remote Physiologic Monitoring (RPM) services to new patients as well as established patients. CMS is also allowing further flexibility in patient consent requirements for such services. Specifically, the agency is finalizing, on an interim basis, that consent to receive RPM services can be obtained once annually (as opposed to requiring more frequent verbal consent from the beneficiary). Furthermore, CMS is clarifying that RPM codes can be used for patients with both chronic and/or acute conditions (i.e., acute respiratory virus).

**Background/Rationale**

To improve patient service access while reducing provider and patient exposure risks, CMS is looking to improve access to RPM. Prior to this rule, RPM services were limited to patients with established relationships, and were burdened with patient consent requirements. CMS hopes that by expanding RPM to new patients, as well as relaxing patient consent requirements, and clarifying that RPM services can address acute medical conditions, providers will deploy more RPM activities for patient affected by COVID-19.

**S. Telephone Evaluation and Management (E/M) Services**

**Proposed Changes**

CMS, on an interim basis for the duration of the COVID-19 PHE, will separately pay for telephone E/M services. These are identified in the interim final rule as CPT codes 98966-98968 (telephone assessment and management services provided by qualified nonphysician health care professionals for established patients, parent, or guardian not originating from a related E/M service provided in previous 7 days nor leading to an E/M service or procedure within 24 hours or soonest available appointment), 99441-99443 (telephone E/M by a physician or other qualified health care professional who may report E/M services for established patients, parent, or guardian not originating from a related E/M service provided in previous 7 days nor leading to an E/M service or procedure within 24 hours or soonest available appointment). These services will be available for both new and established payments; CMS will exercise enforcement discretion for the “established patient” requirement.

Furthermore, CMS clarifies that CPT codes 98966-98968 can be billed by LCSWs, clinical psychologists, as well as PTs, OTs, and SLPs. These are also designated as “sometimes therapy” codes that would require private practice PTs, OTs, and SLPs to include their respective GO, GP, or GN therapy modifier on claims for such services.

**Background/Rationale**

Historically, CMS has listed CPT codes 98966-98968 and 99441-43 as “non-covered services.” CMS rationalizes that, outside of the PHE, if a patient’s needs require a higher level of evaluation or assessment, either an in-person visit or telehealth visit would be warranted (superseding a telephone E/M)—or, alternatively, if a patient’s needs are less acute and lengthy, a virtual check-in would suffice. However, in the context of the current PHE, CMS states there may be several circumstances where E/M services through
audio-only communication may be the only appropriate method of assessment. For example, these codes could be used when two-way, audio and video technology required to furnish a Medicare telehealth service might not be available.

T. Physician Supervision Flexibility for Outpatient Hospitals – Outpatient Hospital Therapeutic Services Assigned to the Non-Surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision

Proposed Changes

CMS will be changing the minimum default level of supervision to “general supervision” for all outpatient hospital therapeutic services. “General supervision” means that the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.

Background/Rationale

CMS believes that changing the minimum supervision requirement for such services will give providers additional flexibilities to handle other burdens created by the COVID-19 PHE.

U. Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic

Proposed Changes

CMS is making three changes to certain elements of National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) through the duration of the PHE.

- **Face-to-face and In-person Requirements**

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 apply to some face-to-face encounter requirements for Durable Medical Equipment, Prosthetic, Orthotic & Supplies (DMEPOS) Power Mobility Devices, which are mandated by statute (e.g. 1834(a)(1)(E)(iv)).

- **Clinical Indications for Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies**

CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management, and infusion pump NCDs and LCDs during the PHE. This is in recognition of the expected reality that such patients may receive care in unexpected settings, including the home. Pages 128-129 of the pre-publication version of the rule include examples of the specific NCDs and LCDs these changes apply to.
• Requirements for Consultations or Services Furnished by or with the Supervision of a Particular Medical Practitioner or Specialist

To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure, or any portion thereof, CMS is allowing the chief medical officer or equivalent of a facility to authorize another physician specialty or other practitioner type to meet those requirements during the COVID-19 PHE. Furthermore, to the extent that the NCDs or LCDs require physician supervision, the same officer can authorize that such supervision requirements do not apply during the COVID-19 PHE.

Background/Rationale

NCDs are determinations by the Secretary with respect to whether an item or service is covered under Medicare. LCDs are determinations by a Medicare Administrative Contractor (MAC) with respect to their particular geographic area.

V. Change to Medicare Shared Savings Program (MSSP) Extreme and Uncontrollable Circumstances Policy

Proposed Changes

• MSSP-Specific Policies:

CMS provides clarification that the Merit-based Incentive Payment System (MIPS) extended reporting deadline and extreme and uncontrollable circumstances policy applies to the MSSP extreme and uncontrollable circumstances policy.

CMS is revising the MSSP extreme and uncontrollable circumstances policy, beginning with the 2019 performance period, by removing the restriction that the policy cannot apply if the reporting period is extended.

CMS also noted that, for the 2020 performance year financial reconciliation, it will reduce the amount of shared losses for ACOs by an amount determined by multiplying the shared losses by the percentage of the total months in 2020 affected by an extreme and uncontrollable circumstance, and the percentage of an ACO’s assigned beneficiaries who reside in those affected areas. For 2020, the PHE applies nationally, therefore, 100 percent of beneficiaries for all ACOs beginning with March and through the end of the PHE.

CMS also notes that it will update ACOs benchmarks to reflect national and regional trends related to 2020 spending and utilization changes, including those arising from the COVID-19 PHE.

• MIPS APM Scoring Standard

Under this section, CMS clarifies the application of the MIPS APM scoring standard under the MIPS extreme and uncontrollable circumstances policy. MIPS eligible clinicians participating in an MSSP ACO and subject to MIPS APM scoring standard, have a different application under the MIPS program. For MIPS APM ACOs, if information is not submitted for one or more categories for the 2019 performance year, the usual reweighting policy will be applied (e.g., if no data is reported for the Quality and Promoting Interoperability categories, then they will be weighted at 0% and the Improvement Activities category will be used to determine the MIPS final score and related 2021 MIPS payment adjustment).
**Background/Rationale**

Under the MSSP’s extreme and uncontrollable circumstance policy, CMS will use an alternative approach for calculating the quality score for ACOs affected by extreme and uncontrollable circumstances during any given performance year. This policy does not apply for performance years if an extreme and uncontrollable circumstance occurs, but the quality reporting period for that performance year (the period during which data must be reported for the performance year) is extended. Because the reporting period was extended in alignment with the MIPS program, the MSSP statute would not allow for the automatic application for the 2019 performance year. As a result, the ACO would receive a quality score of 0 and would not be eligible to share in savings and, if applicable, would owe the maximum losses. CMS is providing this flexibility to offer relief to ACOs for this COVID-19 PHE and future PHEs.

**Comments Requested:** CMS is considering whether its current policy, under which ACOs would as a result receive the higher of the mean quality score across all ACOs and the ACO’s own quality score, would be appropriate. Any changes to this policy would need to be made through future notice and comment rulemaking.

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

**Proposed Changes**

CMS is revising its coding and billing guidelines to specify that the office/outpatient E/M level selection for any services offered via telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. The current definition of MDM remains unchanged. The typical times associated with the office/outpatient E/M are available as a public use file [here](#).

Under the waiver issued by the Secretary pursuant to section 1135(b)(8) of the Act, telehealth office/outpatient E/M can be furnished to any patient in their home regardless of their diagnosis or medical condition.

Furthermore, CMS is removing any requirements regarding documentation of history and/or physical exam in the medical record.

**Background/Rationale**

Prior to the PHE, telehealth office/outpatient E/M could only be furnished to beneficiaries in their homes only when they are for individuals with a substance use disorder (SUD) diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder. For these services, the primary factor in selecting the appropriate level of E/M service to bill would be time spent counseling the patient.

However, the current E/M coding guidelines would preclude the billing practitioner from selecting the office/outpatient E/M code level based on time in circumstances where the practitioner is not engaged in counseling and/or care coordination. CMS is making changes accordingly.
X. Counting of Resident Time During the PHE for the COVID-19 Pandemic

Proposed Changes/Rationale

For the duration of the PHE, CMS is permitting hospitals that are paying resident salaries and fringe benefits for the time that the resident is at home or in the home of a patient that is already a patient of the physician or hospital, but performing patient care duties within the scope of the approved residency program (and meets appropriate physician supervision requirements as stated in section II.O. of this IFC) to claim that resident for indirect medical education (IME) and direct graduate medical education (DGME) purposes.

Background/Rationale

Currently, there is no provision in the regulations for a hospital to claim a resident for IME or DGME if the resident is performing patient care activities within the scope of his or her approved program in his or her own home, or in a patient’s home.

Y. Addressing the Impact of COVID-19 on Part C and Part D Quality Rating Systems

Proposed Changes/Rationale

CMS expresses broad general concern that the COVID-19 social distancing, travel restrictions, and other public health measures will impede a Medicare Advantage (MA) plan’s ability to collect and report data on HEDIS and CAHPS measures for 2021 star ratings. CMS has similar concerns about the Health Outcomes survey (HOS) expected for later in 2020. Accordingly, CMS is amending the calculations for the 2021 and 2022 Part C and D Star Ratings. Broadly, CMS is:

- Replacing the 2021 Star Ratings measures calculated based on HEDIS and Medicare CAHPS data collections with earlier values from the 2020 Star Ratings

CMS is eliminating the HEDIS 2020 submission requirement that covers the 2019 measurement year and is requesting that Medicare plans stop collection work immediately. CMS is making similar regulatory changes for the 2020 CAHPS survey as well. This applies to Part C and Part D plans. The changes do not prohibit plans from collecting HED or CAHPs data, CMS does not expect plans to do so.

To account for the anticipated missing HEDIS and CAHPS scores, CMS will use the 2020 measure-level stars and scores. Without this substitution, CMS would not have enough measures to assess plans on. CMS will use the HEDIS measure scores and Star Ratings based on the 2018 measurement year (which is the data used for the 2020 Star Ratings). Similarly, CMS will use the CAHPS June 2019 data (which is the data used for the 2020 Star Ratings).

Measurement periods for the other measures will not change from what was outlined in the April 2018 final rule. CMS will also continue to exclude the Plan All-Cause Readmissions measure as a display measure for the 2021 Star Ratings.
Outlines how CMS will calculate or assign Star Ratings for 2021 in the event that CMS’ functions become focused on only continued performance of essential Agency functions and the Agency and/or its contractors do not have the ability to calculate the 2021 Star Ratings

CMS highlights the great uncertainty of the COVID-19 PHE have created and the impact they may have on CMS’ ability to calculation 2021 Star Ratings. CMS recognizes that it is critical that MA organizations have certainty in terms of how the ratings would be calculated if CMS were to be compromised.

CMS states that if its resources become extraordinarily compromised, they will use the 2020 Star Ratings as the 2021 Star Ratings.

Modifies the current rules for the 2021 Star Ratings to replace any measure that has a data quality issue for all plans due to the COVID-19 outbreak with the measure-level Star Ratings and scores from the 2020 Star Ratings

CMS states part of their concern driving their decision to potentially use 2020 Star Ratings for 2021 Star Ratings is the fact that data validation of non-HEDIS or CAHPS measures is also subject to risk if the PHE expands further and CMS’ functions become more compromised.

To that end, if CMS has any data validation issues for any non-HEDIS or non-CAHPS, CMS is adopting a rule that would allow them to substitute the score and start for the measure used in the 2020 Star Ratings in the calculation of the 2021 Star Ratings.

In the event that CMS is unable to complete HOS data collection in 2020 (for 2022 Star Ratings), CMS will replace the measures calculated based on HOS data collections with earlier values that are not affected by the PHE for the 2022 Star Ratings

CMS plans to move the HOS survey currently scheduled for April through July 2020 to late summer and will provide MA plans more information on the topic soon. In anticipation of the possibility that the PHE precludes the HOS survey from being collected in the late summer, CMS is amending its regulations for Part C Star Ratings to let CMS use the Star Ratings and measure scores for the 2021 Star Ratings for any measures that come from the HOS survey.

Removing guardrails for the 2022 Star Ratings

For 2022 Star Ratings, CMS still expects plans to submit HEDIS data in June 2021 and to administer the CAHPS survey in 2021 as usual. CMS recognizes that measures for the 2022 Star Ratings are based on the 2020 measurement year, which is ongoing during the PHE. CMS is therefore making changes to 2022 Star Ratings methodology so as not to create inappropriate incentives and to ensure plans that they recognize the likelihood that some measure-level scores will likely decrease.

First, to increase the predictability of the cut points used for measure-level ratings, CMS previously implemented guardrails for measures that were in the program for more than 3 years. These guardrails ensure that measure-threshold-specific cut points for non-CAHPS measures do not increase or decrease more than 5 percentage points from one year to the next. CMS has concerns that this policy could have unintended consequences, including an inability by beneficiaries from being able to distinguish between low performing plans.
As a result, CMS is delaying implementation of the guardrails so that cut points can change by more than 5 percentage points if national performance declines as a result of the PHE.

- **Expanding the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings**

CMS is revising the methodology for the Part C and D improvement measure for the 2022 Star Ratings to expand the hold harmless rule to include all contracts at the overall and summary rating levels recognizing that the PHE may result in a decline in industry performance. The expanded hold harmless provision will apply to all contracts regardless of their ratings and also apply to the Part C and D summary ratings for the 2022 Star Ratings only.

- **Changing QBP Calculations for New Contracts**

CMS is proposing to change the definition of “new plan” for the purposes of the quality bonus payment as a new MA plan if it is offered by a parent organization that has not had another MA contract for the previous 4 years. That would account for how new plans that started in 2019 would have reported HEDIS and CAHPS data to CMS for the first time in 2020 for the 2021 Star Ratings. A new contract with an effective date of January 1, 2019, would normally be treated as new for 2019, 2020, and 2021. The 2022 QBP rating would be based on the 2021 Star Ratings which these contracts will not have due.

**Z. Changes to Expand Workforce Capacity for Ordering Medicaid Home Health Services, Medical Equipment, Supplies and Appliances and Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services**

**Proposed Change**

CMS will allow licensed practitioners practicing within their scope of practice, such as, but not limited to, NPs and PAs, to order Medicaid home health services during the existence of the PHE for the COVID-19 pandemic.

This change does not expand the benefit categories where these items can be covered. States must continue to cover and claim home health nursing and aide services, medical supplies, equipment and appliances, and physical therapy, occupational therapy or speech pathology and audiology services (that are covered under the home health benefit) under the home health benefit, unless otherwise allowed by federal regulations.

**Background/Rationale**

CMS recognizes that increased demand on the direct care services provided by physicians during the PHE for the COVID-19 pandemic could cause a delay in the availability of physicians to order home health services in the normal timeframe. This change is intended to alleviate some of this potential delay in home health services.
AA. Origin and Destination Requirements Under the Ambulance Fee Schedule

Proposed Changes

CMS will temporarily expand the list of destinations at § 410.40(f) 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 Emergency Medical Services (EMS) protocols established by state and/or local laws where the services will be furnished.

A patient suspected of having COVID-19 that requires a medically necessary transport may be transported to a testing facility to get tested for COVID-19 instead of a hospital to prevent possible exposure to other patients and medical staff. This expanded list of destinations will apply to medically necessary emergency and non-emergency ground ambulance transports of beneficiaries during the COVID-19 PHE.

Consistent with section 1861(s)(7) of the Act, there must be a medically necessary ground ambulance transport of a patient in order for an ambulance service to be covered.

Background/Rationale

The origin and destination requirements for coverage of ambulance services are addressed at § 410.40(f). In the context of the PHE for the COVID-19 pandemic, CMS recognizes that providers and suppliers furnishing ground ambulance services and other health care professionals are faced with new challenges regarding potential exposure risks.

BB. Merit-based Incentive Payment System Updates

Proposed Changes

- Improvement Activities:

  CMS is adding a new improvement activity that promotes clinician participation in COVID-19 clinical trials utilizing a drug or biological product to treat a patient with COVID-19, but findings must be reported through an open source clinical data repository or clinical data registry to receive credit.

- MIPS Applications for Reweighting Based on Extreme and Uncontrollable Circumstances:

  CMS is extending the extreme and uncontrollable circumstances reweighting applications deadline for individual clinicians, groups, and virtual groups to April 30, 2020. This extended deadline is only available for those who can demonstrate that they have been adversely affected by the COVID-19 PHE, and it will apply for the 2019 performance year. CMS is also modifying its policy that those if the applicant demonstrates through the application that they have been adversely affected by the COVID-19 PHE, CMS will reweight even those categories for which data was already submitted; essentially, data submission “would not effectively void the application for reweighting.” This also applies to the Promoting Interoperability category hardship application.

Background/Rationale
Improvement Activities:

New activities for this category are generally included through an Annual Call for Activities process with the stakeholder community, however, CMS is making a one-time exception due to the COVID-19 PHE. CMS is not changing the previously finalized submission requirements for the Improvement Activities category.

MIPS Applications for Reweighting Based on Extreme and Uncontrollable Circumstances:

Generally, CMS does not reweight categories for which data has already been submitted. However, recognizing that data submission for the 2019 performance year could have been interrupted and is incomplete due to COVID-19, CMS is modifying this policy.

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

Proposed Changes

Effective for services provided for discharges for patients admitted to the hospital during the COVID-19 PHE, beginning March 1, 2020, if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the hospital.

Background/Rationale

For purposes of Medicare payment, section 1861(b) of the Act defines inpatient hospital services. Routine services in the hospital setting are those described in sections 1861(b)(1) and (b)(2) of the Act. Under current policy for hospital services furnished under arrangements that CMS adopted in the FY 2012 IPPS/LTCH PPS rulemaking, routine services cannot be provided under arrangement outside the hospital. Only the therapeutic and diagnostic services described in section 1886(b)(3) of the Act can be provided under arrangement outside the hospital.

CMS emphasizes that hospitals need to “exercise sufficient control and responsibility over the use of hospital resources in treating patients,” as discussed in the FY 2012 IPPS/LTCH PPS final rule and Section 10.3 of Chapter 5 of the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01). Nothing in the current PHE for the COVID-19 pandemic has changed this policy.

DD. Advance Payments to Suppliers Furnishing Items and Services under Part B

Proposed Changes

CMS will modify existing advance payments rules found in 42 CFR 421.214. First, CMS will the definition of “carrier” to “contractor.” They are also adding paragraph (j) to specifically address emergency situations in which contractors will be able to make advance payments. Existing rules limit 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. Under exceptional circumstances as outlined in paragraph (j) of this section,
CMS is increasing 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 in paragraph (f)(1)(i). CMS will also add a criterion to §421.214 that suppliers in bankruptcy would not be eligible to receive advance payments.

**Background/Rationale**

Currently, §421.214 limits CMS’ ability to make advance payments in situations where a CMS contractor is unable to process claims within established time limits.