

HFMA Executive Summary

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

April 30, 2020

On Thursday, April 30, CMS issued an interim final rule with comment period (IFC) that, for the duration of the COVID-19 public health emergency (PHE),¹ offers providers flexibility by reinterpreting regulations related to telehealth, physician supervision, site of service and other regulatory requirements. CMS believes that providing additional flexibilities to Medicare and Medicaid regulations will help providers combat the COVID-19 pandemic. A detailed summary of the rule is available [here](#).

The following is an executive summary of key provisions included in the IFC.

- 1) **Furnishing Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (Including the Patient's Home):** Under ordinary circumstances, Medicare would not pay for hospital outpatient therapeutic services that are furnished to a beneficiary in the beneficiary's home or any other location that could not ordinarily be provider-based to the hospital.

During the COVID-19 PHE, temporary expansion locations, including beneficiaries' homes, can become provider-based departments (PBDs) of hospitals and therapeutic outpatient hospital services furnished to beneficiaries in these provider-based locations can meet the requirement that these services be furnished in the hospital so long as all other requirements are met, including the hospital conditions of participation, to the extent not waived, during the COVID-19 PHE and the beneficiary is registered as an outpatient of the hospital during care delivery.

The services allowed in temporary locations include partial hospitalization services, hospital in-person clinical staff services in a temporary expansion location (including the home), and hospital services accompanying a professional service furnished via telehealth.

- 2) **Hospital Services Accompanying a Professional Service Furnished Via Telehealth:** During the COVID-19 PHE, when telehealth services are furnished by a physician or practitioner who ordinarily practices in the hospital outpatient department (HOPD) to a patient who is located at home or other applicable temporary expansion location that has been made provider-based to the hospital, CMS believes it would be appropriate to permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services, just as they would have ordinarily done outside of the COVID-19 PHE in this circumstance.

¹ The definition identifies the PHE determined to exist nationwide by the Secretary of Health and Human Services under section 319 of the Public Health Service Act on January 31, 2020, as a result of confirmed cases of COVID-19, including any subsequent renewal

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Effective March 1, 2020, and for the duration of the PHE, when a patient is receiving a professional service via telehealth in a temporary expansion location that is a PBD of the hospital, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service. As always, documentation in the medical record of the reason for the visit and the necessity of the visit is required.

When a practitioner who ordinarily practices in a HOPD furnishes a telehealth service to a patient who is located at home (or otherwise not in a telehealth originating site), they would submit a professional claim with the place of service code indicating the service was furnished in the HOPD and using the CPT telehealth modifier, i.e., modifier 95. Medicare would pay the practitioner under the Physician Fee Schedule (PFS) at the facility rate, as if the service were furnished in the HOPD.

- 3) **Treatment of Certain Relocating Provider-Based Departments During the COVID-19 PHE:** The IFC temporarily implements an expanded version of the extraordinary circumstances relocation policy during the COVID-19 PHE to include on-campus PBDs that relocate off-campus during the COVID-19 PHE for the purposes of addressing the COVID-19 pandemic. CMS's policy has historically applied only to excepted off-campus departments that relocate to a different off-campus location for extraordinary circumstances outside of the hospital's control, that submit an extraordinary relocation exception request to their CMS regional office (RO), and for which the CMS RO evaluates and approves the request. However, on-campus departments that relocate on or after March 1, 2020 through the remainder of the PHE for the purposes of addressing the COVID-19 pandemic may also seek an extraordinary circumstances relocation exception so that they may bill at the Outpatient Prospective Payment System (OPPS) rate, as long as their relocation is not inconsistent with the state's emergency preparedness or pandemic plan.

The temporary extraordinary circumstances relocation policy established by the IFC will terminate following the end of the PHE for the COVID-19 pandemic, and CMS anticipates that most, if not all, PBDs that relocate during the COVID-19 PHE will relocate back to their original location prior to, or soon after, the COVID-19 PHE concludes. Hospitals that choose to *permanently* relocate these PBDs off-campus would be considered new off-campus PBDs billing after November 2, 2015, and therefore, would be required to bill using the PN modifier for hospital outpatient services furnished from that PBD location and would be paid the PFS-equivalent rate following the end of the COVID-19 PHE.

Both excepted off-campus and on-campus PBDs may relocate to off-campus locations during the COVID-19 PHE and begin furnishing and billing for services under the OPPS in the new location

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prior to submitting documentation to the RO to support the extraordinary circumstances relocation request.

To the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient's home, only one relocation request during the COVID-19 PHE is necessary. In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient. Hospitals must send this email to their CMS RO within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD.

Non-expected off-campus departments will continue to be non-expected during the COVID-19 PHE, even if they relocate, and thus, will continue to be paid the PFS-equivalent rate.

- 4) **Indirect Medical Education Payments to Teaching Hospitals:** To accommodate the increase in COVID-19-related patients, many hospitals are increasing their number of inpatient beds. CMS clarifies that it will not count beds added during the PHE in the calculation of indirect medical education payments.

CMS also believes it is appropriate to freeze the inpatient rehabilitation facility's (IRF's) or inpatient psychiatric facility's (IPF's) teaching status adjustment payments at their values prior to the COVID-19 PHE. Therefore, for the duration of the COVID-19 PHE, an IRF's or an IPF's teaching status adjustment payment amount will be the same as it was on the day before the COVID-19 PHE was declared.

- 5) **Medicare Shared Savings Program:** The IFC modifies Shared Savings Program policies to: (1) allow accountable care organizations (ACOs) whose current agreement periods expire on December 31, 2020, the option to extend their existing agreement period by one year, and allow ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for performance year (PY) 2021; (2) clarify the applicability of the program's extreme and uncontrollable circumstances policy to mitigate shared losses for the period of the COVID-19 PHE; (3) adjust program calculations to mitigate the impact of COVID-19 on ACOs; and (4) expand the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication. CMS also address how these adjustments to program policies will apply to ACOs participating in the Track 1+ Model.
- 6) **Payment for Audio-Only Telephone Evaluation and Management Services:** CMS is establishing new RVUs for the telephone evaluation and management (E/M) services it established separate payment for in the March 31, 2020 COVID-19 IFC. Payment is based on crosswalks to the most

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analogous office/outpatient E/M codes, based on the time requirements for the telephone codes and the times assumed for valuation for purposes of the office/outpatient E/M codes.

- 7) **Scope of Practice:** For the duration of the PHE, CMS is making several changes that will expand scope of practice for nonphysician providers. These changes include allowing nonphysician providers to order certain diagnostic tests, therapy assistants furnishing maintenance therapy and pharmacists providing services incident to a physician's service if it is in accordance with the pharmacist's state scope of practice and applicable state law.
- 8) **Rural Health Clinics:** For the duration of the PHE, CMS will use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count for application of this policy. As such, rural health clinics (RHCs) with provider-based status that were exempt from the national per-visit payment limit in the period prior to the effective date of the PHE (January 27, 2020) would continue to be exempt for the duration of the PHE for the COVID-19 pandemic.
- 9) **Merit-based Incentive Payment System Qualified Clinical Data Registry Measure Approval Criteria:** CMS is amending the Qualified Clinical Data Registry (QCDR) measure approval criteria previously finalized in the CY20 PFS final rule. Specifically:
 - a. *Completion of QCDR Measure Testing:* Beginning with the 2022 performance period, all QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure at the time of self-nomination.
 - b. *Collection of Data on QCDR Measures:* Beginning with the 2022 performance period, QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.
- 10) **Update to the Hospital Value-Based Purchasing Program Extraordinary Circumstance Exception Policy:** CMS modifies the Hospital Value-Based Purchasing (VBP) Program's Extraordinary Circumstance Exception (ECE) policy to allow it to grant ECE exceptions to hospitals which have not requested them when CMS determines that an extraordinary circumstance that is out of their control, such as an act of nature (for example, a hurricane) or PHE (for example, the COVID-19 pandemic), affects an entire region or locale, in addition to retaining the individual ECE request policy. In accordance with this updated policy and consistent with the ECE guidance CMS issued on March 22, 2020 and March 27, 2020, 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:

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- a. Hospitals will not be required to report National Healthcare Safety Network (NHSN) healthcare-associated infections measures and HCAHPS survey data for the following quarters: October 1, 2019 – December 31, 2019 (Q419), January 1, 2020 – March 31, 2020 (Q120), and April 1, 2020 – June 30, 2020 (Q220). However, hospitals can optionally submit part or all of these data by the posted submission deadlines on the HVBP QualityNet site.²
- b. 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 (Q120) and April 1, 2020 – June 30, 2020 (Q220).

² CMS QualityNet. "[Participation: How to Participate.](#)"