

CMS payment policies & regulatory flexibilities during COVID-19 emergency

Updated Nov. 11, 2020

The AMA has been working constantly with the Centers for Medicare & Medicaid Services (CMS) to identify issues arising due to COVID-19 and to recommend specific actions to improve Medicare coverage of services and reduce regulatory burdens on physicians during this crisis.

Below are key actions CMS has taken in response to AMA advocacy. Topics include financial assistance, telehealth, the Merit-based Incentive Payment System (MIPS), enrollment, elective surgery and regulatory relief. For the complete list of CMS payment and policy guidance related to COVID-19, please access the CMS website. For the latest information about Medicare coronavirus waivers and flexibilities, visit this CMS website.

Medicare coverage and payment of vaccines and therapeutics

On Oct. 28, CMS issued a fourth COVID-19 interim final rule with comment, which provides coverage and payment details for COVID-19 vaccines and therapeutics. Medicare will cover the cost of COVID-19 vaccines and their administration and will waive out-of-pocket costs for both traditional fee-for-service beneficiaries and beneficiaries enrolled in Medicare Advantage plans. Medicare will pay physicians \$28.39 to administer coronavirus vaccines. For vaccines that require two doses, Medicare will pay \$16.95 for the first dose and \$28.39 for the second dose.

The AMA is carefully analyzing these payment rules and has initial concerns about a lower payment rate for initial vaccine doses. The rule also requires Medicaid, children's health insurance program agencies and most private health plans to administer the vaccine at no cost to patients during the public health emergency. The Department of Health and Human Services (HHS) will cover the vaccine and its administration for any uninsured individuals through the CARES Act Provider Relief Fund.

The press release announcing the rule acknowledges "CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines, which include separate vaccine-specific codes. Providers and insurance companies will be able to use these to bill for and track vaccinations for the different vaccines that are provided to their

enrollees.”

The CPT Editorial Panel is anticipated to vote on COVID-19 vaccine codes during a special meeting this week, and the AMA/Specialty Society Relative Value Scale Update Committee (RUC) may consider recommendations about any approved codes.

Additional notable provisions in the interim final rule include:

- | Physicians and other health care professionals who perform COVID-19 diagnostic tests must post their cash prices online via their website.
- | CMS will pay hospitals add-on payments in the inpatient and outpatient settings for COVID-19 therapeutics.
- | CMS also extends for six months the Comprehensive Care for Joint Replacement (CJR) model, which will now end on Sept. 30, 2021.

The rules are effective immediately and comments are due on Jan. 4, 2021. CMS released additional information including a fact sheet, COVID-19 vaccine resources and FAQs on billing for therapeutics.

CARES Act Provider Relief Fund

The CARES Act Provider Relief Fund was established by Congress to provide financial relief to physicians, hospitals, and other providers during the COVID-19 pandemic. These funds are grants, not loans, and do not need to be repaid. Recipients must agree to terms and conditions for the use of funds and, in many cases, submit financial information to qualify for the funds. The funds may be used either for health care related expenses or for lost revenues that are attributable to coronavirus. HHS is publicly releasing information about recipients and their payments.

In October, HHS began distributing \$20 billion in Phase 3 CARES Act Provider Relief Fund payments to physicians who had previously received payments due to ongoing financial losses and increases in expenses during the COVID-19 emergency. Previously ineligible physicians, such as those who began practicing in 2020, and an expanded group of behavioral health providers were eligible to apply.

In June, HHS distributed \$15 billion in Phase 2 CARES Act Provider Relief Fund payments to eligible physicians and organizations. The payment will be at least 2 percent of reported gross revenue from patient care, and the final amount will be determined based on submitted data, including the number of Medicaid patients served. On Aug. 10, HHS also reversed its prior decision and now allows physicians who faced challenges with the initial distribution a new opportunity to receive funding through Aug. 28, 2020.

In April, HHS announced how it would disburse \$50 billion in “General Distribution” funds to

physicians and other healthcare providers who bill Medicare fee-for-service. HHS first disbursed \$30 billion in automatic payments to hospitals, physicians and other health care providers in direct proportion to their share of 2019 Medicare fee-for-service (FFS) spending. The funds went to each organization's taxpayer identification number which normally receives Medicare payments, not to each individual physician, via Optum Bank with "HHSPAYMENT" as the payment description.

On April 22, HHS announced disbursement of the methodology for an additional \$20 billion for "based on 2018 net patient revenue, not just Medicare fee-for-service. The total \$50 billion General Distribution fund was intended to provide payments based on the lesser of 2 percent of gross patient revenue or the sum of incurred losses for March and April. Eligible physicians must have submitted financial information by June 3, 2020, to qualify for additional funds.

A portion of the Provider Relief Fund is used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured. Physicians are eligible for this funding. Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Steps involve: enrolling as a provider participant, checking patient eligibility and benefits, submitting patient information, submitting claims and receiving payment via direct deposit.

HHS resources

- | Physicians must attest to receipt of the funds and agreement to the fund terms and conditions within 90 days.
- | Additional details about the allocation are available.
- | HHS addressed FAQs about the Provider Relief Fund.
- | Physician can register for and submit claims using the uninsured funding program.

AMA resources

- | Loans and financial assistance for physician practices fact sheet details information about federal government loans and other programs, including the HHS emergency funds.

2020 Merit-based Incentive Payment Program (MIPS) changes

Physicians have the option to opt-out completely or partially from the 2020 MIPS program by completing a hardship exception application and indicating it is due to the COVID-19 public health emergency. The deadline to apply for a MIPS hardship exception is Dec. 31, 2020. The agency also created a new MIPS Improvement Activity to give physicians credit in 2020 for participation in a

COVID-19 clinical trial conducted by the National Institute of Health (NIH) or by reporting through a clinical data repository.

CMS resources

- | CMS Quality Payment Program–COVID-19 Response Fact Sheet (PDF) summarizes the MIPS flexibilities in place.
- | CMS information about the MIPS Improvement Activity for participation in a COVID-19 clinical trial.

CMS resource provides additional guidance to physicians

In an MLN matters article (PDF), CMS offers details about several new Medicare fee-for-service policies in response to the COVID-10 pandemic, including guidance on the appropriate modifiers and place of service codes for billing telehealth services and waiving cost-sharing for COVID-19 testing-related services. CMS continues to update FAQs (PDF) about COVID-19 and Medicare fee-for-service billing, including telehealth, payment for specimen collection for COVID-19 testing and physician services.

CMS further expands Medicare telehealth and testing, clarifies EMTALA flexibilities

The Centers for Medicare & Medicaid Services (CMS) waived additional regulatory requirements and further expanded telehealth in Medicare in an interim final rule (PDF) released on April 30, 2020. In response to efforts by organized medicine, CMS will be increasing payments for audio-only telephone visits between Medicare beneficiaries and their physicians to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about \$14-\$41 to about \$46-\$110, and the payments are retroactive to March 1, 2020. This is a major victory for medicine that will enable physicians to care for their patients, especially their elderly patients with chronic conditions who may not have access to audio-visual technology or high-speed Internet.

During the COVID-19 public health emergency, CMS is forgoing the rulemaking process to add new services to the list of Medicare covered telehealth services, which will be updated on a sub-regulatory basis. CMS is now recognizing audio-only technology for payment for behavioral health services, as identified in their list of telehealth services. CMS also expanded the types of clinicians who can furnish Medicare telehealth services to include physical and occupational therapists and speechlanguage pathologists.

Medicare will also pay physicians and practitioners to assess patients and collect laboratory samples for COVID-19 testing when that is the only service patients receive. Physicians and other clinicians may use CPT code 99211 to bill for services furnished incident to their professional services, for both new and established patients, when clinical staff assess symptoms and collect specimens for purposes of COVID-19 testing. CMS also created a new code, HCPCS code C9803, for hospital outpatient departments to bill for a clinic visit dedicated to specimen collection. Beneficiary cost-sharing is waived for COVID-19 testing and related services.

Finally, CMS issued additional FAQs clarifying Emergency Medical Treatment and Labor Act (EMTALA) requirements and flexibilities during the pandemic.

HHS launches new telehealth website

To help physicians and patients get started with telehealth services, HHS launched the telehealth website with resources and best practices for accessing care virtually. For physicians, there are tips for getting started, preparing patients for telehealth visits, billing and payment, and legal considerations. AMA resources, including the telehealth quick guide, are featured.

Medicare advance payments

Following AMA advocacy efforts, Congress passed significant improvements to the repayment terms of the Medicare Advance Payment Program, including:

- | Postponing the recoupment of disbursed funds until 365 days after the advance payment has been issued to a physician practice; the balance would be due by Sept. 2022.
- | Reducing the per-claim recoupment amount from 100% to 25% for the first eleven months and then 50% of claims withheld for an additional six months. If not repaid in full, the interest rate kicks in.
- | Lowering the interest rate from 10.25% to 4%.

To assist with cash flow challenges during the COVID-19 pandemic, CMS expanded its Advance Payment Program to provide qualifying physicians an emergency upfront payment of up to three months' Medicare payments based on historical claims information from Oct to Dec 2019. Physicians will need to repay this advance.

On April 26, CMS suspended the advance payment program for Medicare Part B suppliers, including physicians.

AMA resources

- | Fact sheet explaining (PDF) the Advanced Payment Program
- | FAQs answering (PDF) common questions about timing, interest and submitting a request

AMA releases special coding advice related to COVID-19

New guidance from the AMA provides special coding advice during the COVID-19 public health emergency. One resource outlines coding scenarios (PDF) to help health care professionals apply best coding practices.

The scenarios include telehealth services for all patients.

There is also a quick-reference flowchart that outlines CPT reporting for COVID-19 testing (PDF).

Medicare expands telehealth during COVID-19 emergency

The Centers for Medicare & Medicaid Services (CMS) lifted Medicare restrictions (PDF) on the use of telehealth services during the COVID-19 emergency. Key changes include:

- | Effective March 1 and throughout the national public health emergency, Medicare will pay physicians for telehealth services at the same rate as in-person visits for all diagnoses, not just services related to COVID-19.
- | Medicare will pay physicians for audio-only telephone calls and has greatly expanded the list of covered telehealth services to include emergency department visits, for example.
- | Physicians utilize telehealth for both new and established patients.
- | Reporting and documentation for office visits performed via telehealth may be based on medical decision-making or time on date of encounter, utilizing 2020 definitions and CMS total time data.

- | Allowing medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), to be performed via telehealth.
- | Patients can receive telehealth services in all areas of the country and in all settings, including at their home.
- | CMS will not enforce a requirement that patients have an established relationship with the physician providing telehealth.
- | Consent for telehealth services may be obtained by staff or the practitioner at any time, required only once on an annual basis.
- | Physicians can reduce or waive cost-sharing for telehealth visits.
- | Physicians licensed in one state can provide services to Medicare beneficiaries in another state. State licensure laws still apply.
- | Physicians can provide telehealth services from their home. Physicians **do not** have to add their home to their Medicare enrollment file.
- | HHS Office for Civil Rights (OCR) offers flexibility for telehealth via popular video chat applications, such as FaceTime or Skype, during the pandemic.

AMA tools and resources:

- | AMA's telemedicine quick guide has detailed information to support physicians and practices in expediting implementation of telemedicine.
- | AMA's coding scenarios (PDF) provide real-world examples of how to code for telehealth services.
- | List of telehealth services (PDF) covered by Medicare and included in the CPT code set

CMS and HHS guidance:

- | CMS interim final rule (PDF) and fact sheet (PDF) detail new regulatory flexibility, relaxed enrollment requirements, expanded telehealth services and revised physician supervision policies to help physicians and patients during the COVID-19 pandemic
- | HHS Office of Inspector General FAQs (PDF) clarify the Administration is allowing broad flexibility for physicians to reduce or waive Medicare beneficiary cost-sharing
- | OCR guidance on telehealth communication methods during the COVID-19 nationwide public health emergency
- | OCR issued FAQs (PDF) about its use of enforcement discretion related to HIPAA and telehealth

Medicare provider enrollment relief

During the national emergency due to COVID-19, CMS will:

- | Allow licensed physicians to provide services to Medicare beneficiaries outside their state of enrollment as long as the physician is licensed in another state. State licensure requirements still apply.
- | Temporarily suspend certain Medicare enrollment screening requirements, including criminal background checks and site visits.
- | Postpone all revalidation actions.
- | Expedite any pending or new enrollment applications.

CMS guidance:

- | CMS fact sheet (PDF) discusses the Medicare enrollment flexibilities in place during the public health crisis
- | CMS enrollment relief FAQs (PDF) clarify that physicians **do not** need to update their Medicare enrollment file with their home address in order to bill telehealth services

Medicare recommendation about elective surgeries and non-essential procedures

On April 19, CMS issued recommendations to guide practices as they consider safely resuming in-person care in regions with low incidence of COVID-19 disease and that have passed the gating criteria according to the Guidelines for Opening Up America Again. Considerations include clinical need, personal protective equipment, workforce availability, testing capacity, and supplies. CMS continues to urge the maximum use of telehealth modalities. Decisions should be consistent with public health information and in collaboration with state public health authorities.

CMS previously issued guidance on postponing non-essential adult elective surgery and medical and surgical procedures to conserve critical resources, such as ventilators and personal protective equipment (PPE), and to minimize the spread of COVID-19 to patients and physicians.

Decisions remain the responsibility of hospitals, surgeons and state and local officials.

CMS guidance:

- | CMS recommendations for providing non-emergent, non-COVID-19 health care (PDF)
- | White House guidelines for opening up America again
- | CMS initial COVID-19 adult elective surgeries and non-essential procedures recommendations

(PDF)

CMS relieves regulatory burdens

CMS has also issued several regulatory burden waivers to provide additional relief, including:

- | CMS is temporarily waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred or otherwise dislocated as a result of the effect of disaster or emergency.
- | For durable medical equipment and prosthetics, orthotics and supplies (DMEPOS) that is lost, destroyed or otherwise unusable, Medicare contractors may waive replacement requirements such as: a face-to-face visit, obtaining new order from a physician and new medical necessity documentation.

CMS guidance:

- | CMS continues to update information about waivers and flexibilities for physicians and health professionals
- | CMS describes waivers for COVID19 in the Emergency declaration health care providers fact sheet (PDF)
- | MLN Matters article (PDF), “Medicare Fee-for-Services (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)”

Medicare payment and coverage policies related to COVID-19

- | Medicare coverage and payment related to COVID-19 fact sheet (PDF)
- | FAQs to assist Medicare providers (PDF)
- | Medicare coverage of services
- | AMA COVID-19 guides
- | COVID-19 CMS guidance
- | COVID-19 telehealth guidance