NCMGMA Medicare Committee Update:

The primary focus of the Medicare Committee this year has been to provide communications covering Medicare coverage/code and program changes and updates. There have been many and . CMS has been busy in 2020 setting the stage for other government and private payers through their approach in updating coverage and reimbursement policies during the COVID-19 public health emergency (PHE), i.e. temporary removal of originating site barriers, expanded telehealth coverage and reimbursement, waived beneficiary copays for certain COVID-19 related visits/procedures, etc. I have attached a table that highlights some of the major changes that we have seen so far.

CMS published two COVID-19 interim rules as well as an Interoperability Final Rule to authorize and allow for the changes needed to address the public health emergency. In addition to all of the COVID-19 adjustments, CMS released the CY 2021 Medicare Physician Fee Schedule Interim Rule in August, which included a number of proposals to extend, transition, or make permanent many of the COVID-19 flexibilities. Some of the highlighted areas proposed in the rule are:

- Make permanent some telehealth services/codes that were added for the PHE
- Revise the definition for "interactive telecommunication systems" to be more broad and inclusive of different modalities
- Direct supervision provided via real-time, interactive audio and video technology
- Developing coding and payment for audio-only visits after the PHE
- Clarified times for prolonged office/outpatient E/M visits which would allow for a payment increase (however, in its current state would be offset by reducing payments for other services)
- A decrease in the conversion factor by $3.83 due to a budget neutrality adjustment that has been statutorily mandated
- Permit NPs, CNS, PAs, and CNMs to supervise performance of diagnostic tests, as well as grant physical and occupational therapists the option to delegate maintenance therapy services to a therapy assistant
- Delay implementation of the MIPS Value Pathways until 2022
- Make key changes to ACO reporting and scoring policies such as sunset the CMS Web Interface, eliminate the MIPS APM scoring standard and replace with the APM Performance Pathway, and a update the MIPS scoring breakdown (Quality = 40%, Cost = 20%, IA = 15%, and PI = 25%)

There have been a number of other flexibilities and changes that CMS has over 2020 in light of the PHE. I have only highlighted a few for the purpose of this summation.

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Summary of COVID-19-Related Regulatory Change Themes

Theme	Purpose of existing regulations	Intended benefit of changes	Potential impact on beneficiaries
Alternative care sites	Set payment rates and clinical requirements for different facility types based on their unique features	Ensure capacity to handle a potential surge of COVID-19 patients through temporary expansion sites	Pro: Provides more choice in sites to access care Con: Patients may not know facility and may be surprised by billing and cost-sharing rates
Benefits and care management	Ensure that beneficiaries have access to certain items and services and quality of care from Medicare providers, facilities, and plans	Cover new services, modify requirements for services, remove prior authorization requirements, and ease requirements for patient assessments and care plans	Pro: Easier access is given to prescription drugs and testing Con: Some patient rights are curtailed, and there is a risk of reduced quality of care
Conditions of participation	Define facility types by characteristics and ensure that providers comply with measures to protect patients and program spending	Ease or waive requirements providers must meet to participate in Medicare	Pro: Access to providers is maintained or expanded Con: Increases risk of reduced quality and risk of fraud, waste, and abuse
Expanded testing	Not applicable	Enable more COVID-19 testing at more locations	Pro: Provides more access to testing Con: Increases risk of surprise billing and cost sharing
Payment systems and quality programs	Ensure that Medicare pays providers appropriately; deters fraud, abuse, and overuse; and incentivizes payment systems to reward value	Waive some payment system and quality requirements to maintain or increase provider payments	Pro: Maintained or expanded access to providers Con: Increases risk of reduced quality of care and higher cost-sharing
Provider capacity and workforce	Limit the provision of some services to certain types of providers	Remove scope-of-practice and other barriers for clinicians to treat patients	Pro: Maintained or expanded access to providers Con: Increases risk of reduced quality of care

Theme	Purpose of existing regulations	Intended benefit of changes	Potential impact on beneficiaries
Reporting and audit requirements	Collect information to improve Medicare program and deter fraud, abuse, and overuse	Limit collection of some information and pause audit activity	Pro: New reporting will yield more information Con: Reporting cuts will yield less information
Safety requirements	Protect patients from serious harm (for example, fires, health care–acquired infections)	Temporarily suspend some safety requirements to reduce provider responsibility and facility traffic	Pro: Provides potential for facilities to focus more on COVID-19 Con: Increases risks to patient safety
Telehealth	Limit use of telehealth to services that may be better suited to the technology and deter fraud, abuse, and overuse	Increase use of telehealth for clinicians to provide services and supervision	Pro: Maintained or expanded provider access; no exposure to risk of COVID-19 infection Con: Increases potential of reduced quality, surprise billing, and cost-sharing

Note: This table summarizes characteristics that are generally shared across changes within each theme category. For more information on individual changes, see the companion policy tracker.
Source: Jennifer Podulka and Jonathan Blum, Regulatory Changes to Medicare in Response to COVID-19, (Commonwealth Fund, August 2020).