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VIA ELECTRONIC SUBMISSION

Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

RE: CMS-1744-IFC: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Interim Final Rule with Comment: **Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency** (IFC). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

General comments

The novel coronavirus, “SARS-CoV-2,” has proven especially dangerous to populations that Medicare serves—people 65 years and older, people who live in a nursing home or long-term care facility, and people of all ages with serious underlying medical conditions, including those with permanent disabilities.¹

¹ Centers for Disease Control & Prevention, “Coronavirus Disease 2019: Situation Summary” (April 19, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html#risk-assessment>.

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Because of this, Medicare Rights greatly appreciates the efforts of the Centers for Medicare & Medicaid Services (CMS) to streamline and enhance Medicare coverage during the public health emergency (PHE). It is vital to find ways to ensure that people with Medicare can comply with public health guidelines, protecting themselves and others, while retaining access to necessary medical treatment and evaluation.

We recognize that it may be appropriate to continue some of these policies beyond the current emergency period. We urge CMS to gather data and engage with stakeholders in order to identify such opportunities and to work with Congress, where necessary, to advance long-term solutions. This may include legislative and regulatory efforts to preserve those rule and waiver changes that expand access and lower barriers to needed care. But before this can begin in earnest, beneficiary-protective and oversight rules must be reinstated as soon as possible to ensure high quality care and services are being provided and to fight against fraud and abuse.

Telemedicine

One area that may be suitable for more permanent policymaking is telemedicine. We particularly approve of the appropriate flexibilities CMS has given to providers in telehealth and other services provided via technology. We suggest that some of these flexibilities—such as the waiver or geographic and originating site restrictions—are important not only during the coronavirus crisis but also moving forward. The enhanced availability of telemedicine, including the limited expansions on the use of audio-only devices, extends access to needed care to rural beneficiaries and also eases burdens on caregivers, transportation services, and the beneficiaries themselves, even in more densely populated areas. We especially appreciate CMS's broader coverage of behavioral telehealth services. Callers to our helpline report both greater access to care and more willingness to seek care under the new system.

We encourage the agency to consider extending many of the commonsense changes made to telemedicine coverage rules. This must be done in evidence-based ways that maximize beneficiary protections. We recognize this policymaking process may take time. Accordingly, we urge CMS to work with Congress to establish a reasonable transition period after the PHE, to ensure coverage for virtual services does not end abruptly or otherwise put people with Medicare at risk.

For example, callers to our helpline include individuals with autoimmune disorders and those who are on immunosuppressants. This makes them more susceptible to viral, bacterial, and fungal infections, and this susceptibility will not evaporate even once the coronavirus emergency ends. Services like telehealth allow those with compromised immune systems to continue to correspond with providers for routine care, follow-ups, and prescription refill appointments, among other services, without having to put themselves at grave risk.

We have, however, heard from many helpline callers whose providers are confused about how to bill for these services, and how or if they can be reimbursed by Medicare. We urge additional outreach on telehealth and other services provided via technology to ensure that Medicare beneficiaries are not misinformed, burdened or overcharged. We urge CMS to require practitioners to educate beneficiaries on any cost sharing that will arise from remote services.

We also caution that even if permanently adopted, many of the recent changes could still leave some beneficiaries without reliable and safe access to needed services. Too many people with Medicare lack access to the devices or internet speeds necessary to make telemedicine feasible. We urge CMS to reinvestigate whether additional services could be offered through audio-only interfaces without unduly putting beneficiaries at risk of fraud and abuse or curtailing their access to in-person care. Any such changes would likely require significant outreach, education, and oversight.

Finally, it remains essential that, should these additional telehealth flexibilities remain after the end of the PHE, these services are optional, rather than mandatory or functionally mandatory for beneficiaries. Telehealth must not be incentivized in such a way that in-person treatment and consultation is harder to access, and provider compliance with accessibility requirements may not be sidestepped by offering telemedicine. Beneficiaries will vary in their comfort with telemedicine and CMS should not substitute online access for in-person access without express and informed choice.

Home Health

CMS has expanded the definition of “homebound” for the purposes of home health to apply when there is a risk of contracting or spreading coronavirus. We support this interpretation and suggest that it is appropriate to adapt the definition in perpetuity to ensure that Medicare beneficiaries have greater access to home health when they need it because of their health status. For example, as we discussed above in the context of telemedicine, some individuals must always be extremely cautious about travel outside the home because of their immunocompromised status, and it may be unadvisable for them to leave their homes even if it is not physically difficult for them to do so. We encourage CMS to retain the broader definition of homebound for access to home health care services and also to modify it to apply to non-COVID risks.

Protective and Oversight Rules

That said, we also urge CMS to revert other flexibilities as soon as is feasible. While the coronavirus makes some face-to-face encounters less safe, and it is appropriate for many such requirements to be waived right now, many of these rules are there for a reason. Going

forward, we must reestablish those requirements for supervision, assessment, and timeliness that are necessary to ensure people with Medicare have appropriate care delivered professionally and competently.

In the following comments we provide more detail regarding areas where the new flexibilities should be retained in some form and areas where we urge a rapid resumption of previous rules.

II. Provisions of the Interim Final Rule

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

1. Site of Service Differential for Medicare Telehealth Services

CMS is currently paying the in-person rate for services furnished via Medicare telehealth if the services would have been furnished in person if not for the public health emergency. We understand the need to maximize access to telehealth during this time. However, we are concerned that adopting this payment structure on a more permanent basis may create financial incentives for providers that inadvertently put beneficiary health and agency at risk. To inform any future policymaking, we urge CMS to collect and make publicly available data examining the effects of this payment system on beneficiary choice.

If the payment structure incentivizes providers to provide in-person care instead of remote care, many providers may choose the in-person option when the remote option would better serve the needs of the beneficiary, or vice versa. We urge CMS to monitor the provision of remote care closely to ensure that beneficiaries have adequate access to in-person care once the public health emergency has ended. Many beneficiaries may prefer face-to-face visits or may have technology hurdles that make remote care unworkable or burdensome. They must not be discriminated against.

2. Adding Services to the List of Medicare Telehealth Services

To determine if Medicare should pay for a telehealth service, CMS compares it to those currently covered. If it is dissimilar, CMS requests evidence that providing it via telehealth would be clinically beneficial. For the duration of the public health emergency, CMS has determined that a larger number of services will meet this threshold because of the new risks to beneficiaries, health care workers, and the community from in-person visits. We appreciate and applaud this change.

We support adding services to the list of Medicare-covered telehealth services to the extent that such services can be provided safely and effectively through remote technologies. We urge CMS to monitor beneficiary outcomes to ensure that such services prove clinically appropriate

and that the feasibility of fulfilling all of the required elements of a service via communication technology is borne out by evidence. We also urge that as many clinically appropriate services as possible are available remotely past the expiration of the public health emergency, whether permanently or as necessary to ensure a smooth transition from virtual to in-person care, and that risks for returning to in-person visits are carefully weighed before any telehealth availability is ended to ensure safety and continued access to care.

16. Therapy Services

In this IFC, CMS expands the list of therapy services available remotely while holding in place the requirement that such services be furnished and billed by eligible distant site practitioners. While we support this expansion, we are glad to see that it has been subsequently extended to include physical therapists, occupational therapists, and speech language pathologists.²

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

CMS is waiving frequency limitations for some services to be delivered in person, including certain care for hospital inpatients and nursing facility residents where the agency previously believed that the potential acuity of the patients made such limitations necessary. While we support the temporary relaxation of this rule to protect residents during the public health emergency, we urge CMS to closely monitor outcomes for beneficiaries to ensure that removing this requirement is clinically appropriate and that the feasibility of fulfilling all of the required elements of a service via communication technology is borne out by evidence. We understand that providers may prefer fewer restrictions, but that does not mean that a permanent relaxation of these limitations is in the best interests of beneficiaries.

Similarly, regarding critical care consultations and hands-on visits for ESRD monthly capitation payments, we urge the agency to collect data and assess the outcomes for beneficiaries under the new system and base decisions on the clinical appropriateness of permanent easing of these requirements once the public health emergency has ended.

C. Telehealth Modalities and Cost-sharing

1. Clarifying Telehealth Technology Requirements

² Centers for Medicare & Medicaid Services, “COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers” (May 15, 2020), <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

CMS clarifies that, for the duration of the emergency, an interactive telecommunications system includes phones that can be used for two-way, real-time interactive audio and video communication between a patient and a provider. We appreciate this clarification. However, we urge CMS to explore ways to make remote care more available for beneficiaries who do not have the capability for video communications. People with Medicare may lack access to a video device or to the network or connectivity required for effective communication.

2. Beneficiary Cost-sharing

The Office of the Inspector General issued a policy statement notifying physicians and other practitioners that they will “not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules.”³ We appreciate this policy statement and hope many practitioners will choose to waive cost sharing for telehealth during the emergency. However, we have received numerous reports on our national helpline that beneficiaries are facing widespread confusion and, in some cases, misinformation from providers about their cost-sharing obligations. This has led to some beneficiaries receiving bills that they were not expecting because their providers had assured them the services would not lead to cost sharing. We urge CMS to do more education and outreach to providers to ensure that beneficiaries are not left with surprise bills for services, particularly around the difference between services for which Medicare/ Medicare Advantage plans must cover a service at 100% and those for which providers may waive cost sharing. CMS must also ensure plans and providers are not engaging in deceptive marketing, outreach, or billing practices, however unintentional.

D. Communication Technology-Based Services (CTBS)

CMS is relaxing enforcement of the requirement that Communication Technology-Based Services such as remote patient monitoring and virtual check-ins be reimbursable only if provided to existing patients. We support this change which avoids unnecessary barriers to care.

CMS is also making clear that consent to receive these services must be obtained annually, but may be obtained by auxiliary staff at the same time that a service is furnished. We urge CMS to monitor beneficiary consent to receive services very closely to ensure that beneficiaries are truly agreeing to the services and concomitant cost sharing. Callers to our national helpline

³ Office of the Inspector General, “OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak,” Dept of Health & Human Services (March 17, 2020), <https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf>.

reveal that there is widespread confusion among providers as to how cost sharing works for remote services, and there is a strong potential for beneficiaries to agree to services without understanding what financial obligations they may be incurring. Beneficiaries must not be expected to pay for services if they are given inaccurate or misleading information, for example if they are told there is no cost sharing associated with them.

CMS has also broadened the use of remote evaluation and virtual check-in codes to include services provided by practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists. We support this broadening which helps to ensure appropriate care is safely delivered.

E. Direct Supervision by Interactive Telecommunications Technology

CMS is allowing the direct supervisory portion of some services that require physician or nonphysician practitioner supervision to be supplied using real-time interactive audio and video technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We support this change for the duration of the emergency. It may help reduce the number of individuals Medicare beneficiaries encounter during a visit and allow supervising practitioners to continue to practice even under quarantine. It may also increase access to these services by allowing practitioners to cover more physical territory. At the same time, we urge caution and oversight to ensure that practitioners are not spread too thin to be providing truly useful supervision.

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

CMS has clarified that during the PHE, beneficiaries are to be considered “homebound” if it is medically contraindicated for them to leave the home, including because they have a confirmed or suspected diagnosis of COVID-19, or a condition that may make them more susceptible to contracting the virus. Under this interpretation, someone who is exercising “self-quarantine” but lacks such a certification would not be considered “homebound.” However, the Centers for Disease Control has advised older adults and individuals with serious underlying health conditions to stay home,⁴ which puts many Medicare beneficiaries into the “confined to the home” category. CMS also clarifies that determinations of whether home health services are reasonable and necessary, including whether the patient is homebound and needs skilled services, must be based on an assessment of each beneficiary’s individual condition and care needs. As we described above in relation to remote care, many people with Medicare are more at risk of severe complications from infectious diseases than the general population and benefit

⁴ Centers for Disease Control and Prevention, “People Who Are at Higher Risk for Severe Illness” (May 14, 2020), (<https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>).

from being able to stay at home whenever possible. Looking ahead, we encourage CMS to consider ways to maintain and expand upon this understanding of “homebound” in order to best grant more options for home health for those with compromised immune systems or chronic illness that increases their risk.

H. The Use of Telecommunications Technology Under the Medicare Hospice Benefit

CMS has amended the hospice regulations on an interim basis to specify that hospices may provide services via a telecommunications system if it is feasible and appropriate to ensure that Medicare beneficiaries receive reasonable and necessary care. The use of such technology must be included on the plan of care and must be tied to patient-specific needs. We support these amendments and urge CMS to investigate whether such technological services should be available after the end of the public health emergency.

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

CMS has determined that a face-to-face visit solely for the purpose of recertification for Medicare hospice services is considered an administrative requirement and could be performed via telecommunications technology as a result of the PHE for the COVID-19 pandemic. We support this determination but only for the duration of the public health emergency. We do not believe this change should be made permanent.

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

CMS is temporarily allowing the face-to-face visit requirements for IRFs to be conducted via telehealth to safeguard the health and safety of Medicare beneficiaries and the rehabilitation physicians treating them. We support this temporary modification of the face-to-face requirements, but do not support it as a permanent change.

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

CMS has removed the post-admission physician evaluation requirement for all IRFs during the public health emergency, claiming that this will “greatly reduce the amount of time rehabilitation physicians in IRFs spend on completing paperwork requirements when a patient is admitted to the IRF, and will free up their time to focus instead on caring for patients and helping where they may be needed with the PHE for the COVID-19 pandemic.”⁵ CMS notes that this does not preclude an evaluation if the IRF believes the patient’s condition warrants it. We

⁵ 85 Fed. Reg. 19230, 19252.

oppose this change. As CMS states in the IFC, the post-admission physician evaluation “documents the patient’s status on admission to the IRF, includes 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.”⁶ Documenting a patient’s status and ensuring that this status matches the expected status, as well as taking initial steps toward an individualized plan of care are not purely “paperwork” functions. The public health emergency must not be used as an excuse to reduce the person-centered care and attention people with Medicare receive, and all patients admitted to the IRF have conditions that warrant evaluation. The initial evaluation is partially to determine if the patient’s condition matches expectations.

CMS is also clarifying that IRFs “should not feel obligated to meet the industry standards” for provision of therapy but “should instead make a note to this effect in the medical record.” This instruction is extraordinarily vague, potentially harmful, and overly permissive. CMS must immediately clarify that the IRF’s obligation to meet industry standards remains intact, and that facilities must document true attempts and failures to meet their obligations.

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

1. Expansion of Virtual Communication Services Furnished by RHCs and FQHCs

b. Improving Access to Care Management and Virtual Communication Services Furnished by RHCs and FQHCs

CMS is allowing RHCs and FQHCs to provide services remotely for new and established patients. We support these changes and encourage CMS to learn more about beneficiary experiences in accessing this care, before the agency considers adopting any longer-term changes.

CMS is also allowing practitioners to obtain consent for services at the time the services are provided, as well as allowing staff to obtain the consent. We view this policy with significant caution. As we said above, we urge CMS to monitor beneficiary consent to receive services very closely to ensure that beneficiaries are truly agreeing to the services and concomitant cost sharing. Callers to our national helpline reveal that there is widespread confusion among providers as to how cost sharing works for remote services, and there is a strong potential for beneficiaries to agree to services without understanding what financial obligations they may be incurring. Beneficiaries must not be expected to pay for services if they are given inaccurate or

⁶ 85 Fed. Reg. 19230, 19252.

misleading information, for example if they are told there is no cost sharing associated with them.

2. Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting Nursing Services

b. Revision of Home Health Agency Shortage Area Requirements for Furnishing Visiting Nursing Services

CMS has determined that any area typically served by the RHC or that is included in the FQHCs service area plan, will be considered as having a shortage of home health agencies, which means such practitioners will not need to seek a separate determination in order to provide covered visiting nurse services. Such visiting nurse services would not be covered if they were found to overlap with a 30-day period of home health care. We support this change which will help ensure that people with Medicare who are homebound receive the care they need.

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

CMS is allowing for payment to independent laboratories for specimen collection for COVID-19 testing under certain circumstances. We support this change to better ensure sufficient safe access to testing for people with Medicare.

N. Requirements for Opioid Treatment Programs (OTP)

CMS has revised the requirement of interactive two-way audio/video communication technology to furnish the counseling and therapy portions of the weekly bundle of services furnished by OTPs and is now permitting those services to be provided using audio-only telephone calls. We support this change and urge CMS to make it permanent. In addition, we encourage CMS to explore other areas where audio-only remote care is a feasible and reasonable option that would greatly extend the reach of telemedicine. Many people with Medicare do not have access to the technology or strong internet signals that would allow useful video communication. Requiring video may unreasonably restrict those who are economically disadvantaged or who live in rural areas from accessing telehealth and other remote care.

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

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

CMS has relaxed the requirement for the physical presence of teaching physicians when residents have provided the entirety of a service by allowing that supervision to be met through interactive telecommunications technology. Similarly, when services require direct supervision, CMS has relaxed the requirement to allow such supervision to be provided through interactive telecommunications technology for all levels of an office/outpatient evaluation or management service provided in primary care centers, the interpretation of diagnostic radiology and other diagnostic tests, and the provision of psychiatric services.

We support these changes for the duration of the emergency to reduce the number of individuals Medicare beneficiaries encounter during a visit and to allow teaching physicians to continue teaching even if under quarantine. At the same time, we urge caution and oversight to ensure that practitioners are not spread too thin to be providing truly useful supervision.

Importantly, CMS has declined to extend these relaxed requirements to surgical, high-risk, interventional, or other complex procedures, procedures performed through an endoscope, or anesthesia services. We support these exceptions.

c. Application of the Expansion of Telehealth Services to Teaching Physician Services

Similarly to the above, CMS is permitting Medicare payment for telehealth services that are billed by teaching physicians and furnished by residents. This includes services that require the physical presence of the teaching physician as well as those that require direct supervision. As above, we support these changes for the duration of the emergency to reduce the number of individuals Medicare beneficiaries encounter during a visit and to allow teaching physicians to continue teaching even if under quarantine. At the same time, we urge caution and oversight to ensure that practitioners are not spread too thin to be providing truly useful supervision.

d. Payment under the PFS for Teaching Physician Services when Resident under Quarantine

CMS has clarified that these relaxed requirements would also cover residents who are themselves under quarantine and providing services that require physician presence or direct supervision. We appreciate this clarification.

e. Revisions to Moonlighting Regulations during a PHE for the COVID-19 Pandemic

Under certain conditions, CMS is allowing residents to bill for services that are not related to their approved GME program. In part, these services must be separately billable and performed in the inpatient setting of a hospital in which they have their training program. We support this change for the duration of the public health emergency to ensure there are licensed practitioners available to furnish services and critically needed care.

Q. Innovation Center Models

1. Medicare Diabetes Prevention Program (MDPP) expanded model Emergency Policy

CMS is seeking to permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increase the number of virtual make-up sessions, and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis. We support these actions which will prevent people with Medicare who were engaged in an MDPP during the public health emergency from being penalized by being unable to continue to attend sessions.

R. Remote Physiologic Monitoring (RPM)

CMS has extended the availability of payment for RPM to new patients, as well as to established patients. We support this change.

CMS also has relaxed the requirement for beneficiary consent to allow it to be obtained once annually, including at the time services are furnished, with only a suggestion that the physician or other health care practitioner review consent information with a beneficiary, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained. We have serious concerns with this change, even on a temporary basis. Even during optimal public health circumstances, obtaining informed beneficiary consent can be a challenge. The coronavirus pandemic is only making this more difficult—and more critical. Callers to our helpline demonstrate that there is widespread confusion about remote services and many beneficiaries may not understand what they are agreeing to pay. We urge the agency to change this suggestion to a requirement in order to demonstrate that beneficiaries truly understand their financial obligations from remote services.

CMS is also allowing RPM codes to be used to capture monitoring of patients with acute conditions in addition to the normal use of RPM for chronic conditions. We support this change to ensure beneficiaries do not have to make unnecessary in-person clinical visits so long as the RPM provides value safely.

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

CMS is extending the availability of payment for telephone-only E/M services, including for both new and established patients. We support this extension of services during the public health emergency and we urge CMS to consider ways to permanently extend remote care to those who lack video capabilities. Requiring video for telehealth services creates a barrier for too many Medicare beneficiaries who may lack the equipment or internet necessary for video visits.

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

1. Face-to-face and In-person Requirements

CMS has waived face-to-face and in-person requirements for evaluations, assessments, certifications or other implied face-to-face services for NCDs and LCDs for the duration of the coronavirus public health emergency. While we recognize the need to reduce person-to-person contact, we encourage CMS to retain these requirements and allow flexibility for them to be provided remotely.

2. Clinical Indications for Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies

CMS has announced it will not enforce the clinical indications for coverage across respiratory, home anticoagulation management, and infusion pump NCDs and LCDs. We support this decision during the public health emergency to ensure that more beneficiaries have access to the care, equipment, and supplies they need to stay safe and healthy in their homes. However, such changes increase the risk of fraud and we urge robust oversight.

3. Requirements for Consultations or Services Furnished by or with the Supervision of a Particular Medical Practitioner or Specialist

CMS has relaxed the requirements in many NCDs and LCDs that limit coverage to specific practitioner types furnishing services or procedures. On an interim basis, the agency is allowing the chief medical officer or equivalent to authorize another physician specialty or practitioner type to meet those requirements. In addition, the agency has given a blanket waiver to the requirement for a physician or physician specialty to supervise other practitioners to meet the conditions of an NCD or LCD. While the availability of certain physicians and specialists may be impacted by the public health emergency, it is inappropriate to allow widespread substitution for specific practitioner types. We urge the agency at a minimum to require documentation of the need for a different provider type and an explanation of the substitution's clinical adequacy. We also oppose a blanket waiver for the supervision requirements. Instead, we encourage the agency to investigate similar modifications as discussed in other sections above to allow for remote supervision or other temporary measures that do not threaten beneficiary health or access to care.

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

CMS is expanding the practitioners who can order Medicaid home health services—including nursing and aide services, medical supplies, equipment and appliances and physical therapy, occupational therapy or speech pathology and audiology services—from physicians to other licensed practitioners within their scope of practice, including nurse practitioners and physicians’ assistants. We support this change which should allow beneficiaries to gain smoother access to services.

AA. Origin and Destination Requirements Under the Ambulance Fee Schedule

CMS has expanded the list of covered destinations for Medicare ground 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. This could include transportation to a testing facility to get tested for COVID-19 instead of a hospital in an effort to prevent possible exposure to other patients and medical staff. We support this temporary expansion.

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

CMS is allowing hospitals broader flexibilities to furnish inpatient services, including routine services, outside the hospital during the public health emergency. CMS is not relaxing the requirement for hospitals to exercise sufficient control and responsibility over the use of hospital resources in treating patients. We do not object to this change on a temporary basis as it may be needed to ensure that hospitals are able to use their full capacity to provide care for Medicare beneficiaries during this unprecedented crisis.

Thank you again for the opportunity to comment on this rule’s proposals. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,



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