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July 7, 2020

## VIA ELECTRONIC SUBMISSION

Center for Medicare  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Baltimore, MD 21244-1850

### **RE: CMS-5531-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; 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**

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Interim Final Rule with Comment: **Medicare and Medicaid Programs, Basic Health Program, and Exchanges; 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** (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**

As we enter the second half of the year, it is clear the novel coronavirus, “SARS-CoV-2,” is not going to go away quickly. The virus poses a significant risk for individuals who are overwhelmingly represented in the Medicare beneficiary population—people 65 years and

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older, people who live in a nursing home or long-term care facility, and people of all ages with serious underlying medical conditions.<sup>1</sup> Because of these significant and widespread risks, 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.

While we urge the administration to again extend the emergency period, we also urge CMS to have a plan in place to unwind the flexibilities that run alongside it in ways that will ensure a smooth glide path for beneficiaries and providers. We also continue to encourage the agency to explore opportunities to extend and improve some of these forms of access, working with Congress where necessary. But protective and oversight rules must be reinstated as soon as possible, some of them before the end of the public health emergency, in order to best provide high quality care that meets the needs of people with Medicare.

As the pandemic continues, additional changes may be necessary to advance these goals. For example, the shift to telehealth has revealed how many beneficiaries lack access to and comfort with reliable, affordable video technologies and broadband services. We urge thoughtful consideration of ways to ensure all beneficiaries can obtain care remotely and in-person, and that the provision of health care via technology does not exacerbate longstanding racial and socioeconomic disparities.

## **B. Scope of Practice**

### **1. Supervision of Diagnostic Tests by Certain Nonphysician Practitioners**

The Centers for Medicare & Medicaid Services finalized changes to add flexibility for non-physician practitioners to provide care up to the limits of their state scope of practice related to diagnostic tests. We support this temporary provision. Allowing providers to operate at the top of their licenses in such instances can help beneficiaries find the care they need.

### **2. Therapy – Therapy Assistants Furnishing Maintenance Therapy (PFS)**

CMS is permitting therapy assistants to provide maintenance therapy in Part B to the same extent that such assistants are permitted to provide maintenance therapy in Part A. We support this synchronization as it will increase beneficiary access to therapy and reduce confusion.

## **C. Modified Requirements for Ordering COVID-19 Diagnostic Laboratory Tests**

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<sup>1</sup> 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>.

On an interim basis, CMS has removed the requirement that certain diagnostic tests are covered only based on the order of a treating physician or non-physician practitioner, but may cover COVID-19 tests when ordered by any health care professional authorized to do so under state law. In addition, CMS is removing the same ordering requirements for influenza and another common respiratory virus because of their similar presentations. We support these changes to help ensure that people with Medicare have access to needed testing. We encourage CMS to continue to explore ways to expand COVID-19 testing capacity and to increase transparency around data collection to better identify health disparities.

#### **D. Opioid Treatment Programs (OTPs) – Furnishing Periodic Assessments via Communication Technology**

During the public health emergency, CMS is allowing the therapy and counseling portions of the weekly bundles of services furnished by Opioid Treatment Programs (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 technology, if beneficiaries do not have access to two-way audio/video technology. We support this policy. We urge CMS to explore ways to make this provision permanent to ensure that people who need the services of an OTP have access to care. Many Medicare beneficiaries lack access to the technology, network or bandwidth, or data plans that make video calls feasible and affordable. Because of this, audio-only interactions can greatly improve the reach of OTPs. In addition, we urge CMS to thoughtfully explore what other services beyond OTPs can be provided safely and effectively via audio-only telehealth and to work with legislators where necessary to consider ways to expand these options.

CMS is also allowing periodic assessments to be furnished via two-way interactive audio-video technology and, where necessary, through audio-only technology. As above, we support this effort to allow greater access for people with Medicare.

#### **E. Treatment of Certain Relocating Provider-Based Departments During the COVID-19 PHE**

##### **4. Extraordinary Circumstances for Relocating PBDs During the PHE for the COVID-19 Pandemic; 5. New Exception Process for Extraordinary Circumstances Relocation of Existing On-Campus and Excepted Off-Campus PBDs**

CMS is temporarily adopting an expanded version of the extraordinary circumstances relocation policy during the COVID-19 public health emergency. This is intended to help hospitals repurpose existing space for use as temporary expansion sites to furnish inpatient and outpatient care. We support efforts to aid hospitals in making care more accessible during the

public health emergency, including where the hospitals divide provider-based departments across several sites, including patient homes.

## **F. Furnishing Outpatient Services in Temporary Expansion Locations of a Hospital or a Community Mental Health Center (including the Patient’s Home)**

### **a. Partial Hospitalization Program (PHP)**

#### **(ii.) Community Mental Health Centers (CMHC)**

CMS is now permitting the provision of PHP services to CMHC patients in their homes. We support this flexibility to ensure services are available safely to people with Medicare.

### **L. Medicare Shared Savings Program (MSSP)**

#### **2. Allow BASIC Track ACOs to Elect to Maintain Their Participation Level for One Year**

For 2021, CMS will not automatically advance Accountable Care Organizations (ACOs) to the next level of risk categorization. We support this provision.

However, for 2022, CMS will automatically advance ACOs to the same level of risk that they would have encountered, skipping intermediate levels. As a result, an ACO that is currently at level B will not automatically move to level C in 2021 but will jump to level D in 2022. This is a mistake and is likely to drive ACOs out of the MSSP. Skipping a level in the best circumstances would be difficult for most providers. The months and years directly following the public health emergency will undoubtedly be filled with more uncertainty than previously anticipated. We urge CMS to reconsider this provision.

## **M. Additional Flexibility under the Teaching Physician Regulations**

CMS has extended the teaching physician regulation flexibilities offered under the March 31<sup>st</sup> IFC and now allows the flexibilities to apply when a resident furnishes services permitted under the primary care exception, including via telehealth, and the teaching physician can provide the necessary direction, management, and review of the resident’s services using interactive audio/video real-time communications technology. As we expressed in our comments on the March 31<sup>st</sup> IFC,<sup>2</sup> we support these changes for the duration of the emergency to reduce the number of individuals Medicare beneficiaries encounter to receive their care and to allow teaching physicians to continue under quarantine. At the same time, we urge caution and

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<sup>2</sup> Medicare Rights Center, “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (June 1, 2020), <https://www.medicarerights.org/policy-documents/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

oversight to ensure that practitioners are not spread too thin to offer truly useful supervision. We urge CMS to study the outcomes, billing patterns, and impacts on racial and socioeconomic disparities that may result from any increased uptake in Medicare telehealth.

#### **N. Payment for Audio-Only Telephone Evaluation and Management Services**

Audio-only remote care has extended access to care for many people with Medicare who do not have the technology or internet necessary for high-quality video. We urge CMS to closely monitor the use of audio-only services to ensure that they are clinically appropriate and to determine what services should continue to be available through audio-only means after the end of the public health emergency.

CMS notes that practitioners “should educate beneficiaries on any applicable cost sharing” for audio-only telemedicine services and seeks comment on how best to minimize unexpected cost sharing for beneficiaries.<sup>3</sup> We urge CMS to strengthen this language from “should” to “must.” Beneficiaries need practitioners to provide this education. In turn, providers need accurate and adequate guidance from CMS. Callers to our national helpline report widespread confusion and misinformation that results in cost-sharing bills that beneficiaries did not expect. Clear education is especially vital at a time when some providers may be waiving cost sharing while others continue to collect it, and where the difference between a phone conversation that rises to the level of a telemedicine service and one that does not may be difficult for patients to assess or apprehend.

#### **V. COVID-19 Serology Testing**

CMS has determined that Medicare will cover an FDA-authorized serology test that detects antibodies to SARS-CoV-2. We support this determination, which will ensure greater testing access for Medicare beneficiaries.

#### **Y. Requirement for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19**

CMS has added a new provision to require facilities to inform residents, their representatives, and their families of confirmed or suspected COVID-19 cases in the facility among residents and staff. The disclosures must be made by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19; or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours of each other. Facilities must include information on mitigating actions implemented to prevent or reduce the risk of transmission,

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<sup>3</sup> 85 Fed. Reg. 27550, 27590.

including if normal operations in the nursing home will be altered. We support this new provision and encourage stringent oversight and public reporting.

CMS is permitting facilities to communicate this information through paper notification, listservs, website postings, and/or recorded telephone messages. We urge CMS to require facilities to communicate both directly (i.e. through paper notification, email when an email address is available, or telephone messages) and indirectly (i.e. through website postings). This will provide the greatest likelihood that the residents, representatives, and families will be truly informed.

#### **AA. Updating the Medicare Telehealth List**

CMS continues to update the Medicare telehealth list through a sub-regulatory process. We appreciate the speed and flexibility such a process allows during the public health emergency and support its use to ensure beneficiaries have access to care. However, we urge CMS to return to a formal rulemaking process as soon as possible to afford stakeholders a true opportunity to be heard.

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](mailto:LCopeland@medicarerights.org) or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at [JCarter@medicarerights.org](mailto:JCarter@medicarerights.org) or 202-637-0962.

Sincerely,



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