Wynne Health Group

Memorandum

March 31, 2020

IN SWEEPING SET OF CHANGES, CMS OPENS UP NEW FLEXIBILITIES TO PROVIDERS FOR COVID-19 RESPONSE; ADDITIONAL DETAILS INCLUDED FOR PLANS AND STATE SURVEYORS

The Centers for Medicare & Medicaid Services (CMS) **instituted a sweeping array of new provider flexibilities for supporting the health care system's response to the COVID-19 pandemic** (press release). The changes leverage many of the avenues available to the agency in affecting policy, importantly including blanket 1135 waiver authority and the agency's interim final rulemaking ability.

First, **CMS outlines its emergency declaration blanket waivers**, invoking section 1135 waiver authority, in an expansive fact sheet here (additional detail with illustrative examples on application of the blanket waivers here). In summary, the fact sheet outlines several key new flexibilities, organized primarily by provider type and captured in the table below (*section I*). **These new waiver flexibilities are effective as of March 1, 2020 and may be used without notifying CMS**. They will remain in place through the end of the emergency declaration.

In addition to these blanket waivers, **CMS also issued an interim final rule with comment period (IFC)** that includes additional temporary flexibilities for providers not covered in the blanket waiver. These changes are intended to remain in effect for the duration of the public health emergency and are also applicable as of March 1, 2020. **Comments on any of the provisions in the IFC are due 60 days following its publication in the Federal Register, or approximately by May 31, 2020**. *See more detail in section II below*.

Together, these sets of changes are intended to allow providers the ability to more swiftly respond to the growing needs of the COVID-19 pandemic, including important supports for infection control and prevention. Providers will be able to offer services via telehealth more broadly, and in some cases by audio-communication only. The changes also expand the available health care workforce by allowing more practitioners to deliver services, and will also enhance the capacity for providers to treat the growing number of patients by permitting them to deliver off-campus care in new facility types (e.g., hotels and convention centers). Hospitals and dialysis centers may also establish COVID-only centers to help reduce transmission to other patients and health care workers. Last, the administration is attempting to alleviate burden on providers by rolling back certain regulatory requirements on reporting deadlines and other documentation requirements. A high-level infographic on these changes is provided here. As mentioned above, a list of illustrative examples for how providers can apply these new flexibilities begins on p. 6 here.

Last, CMS provided additional information to State Surveyors and Accrediting Organizations, and Medicare Advantage (MA) and Part D plan sponsors. The information covers reprioritization changes to non-emergency survey inspects, as well as its reprioritization of risk adjustment data validation (RADV) audit activities. *See section III below for more detail*.

I. Further details on the 1135 blanket waivers follow.

Table: Blanket Waiver Flexibilities by Provider Type (full list here)

Provider Waivers	Description
Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs), including Cancer Centers and Long-Term Care Hospitals (LTCHs) *(p. 1)*	Several waivers, including allowing providers to screen patients for COVID-19 in offsite locations; requirements limiting use of verbal vs. written orders; reporting requirements; personal protective equipment (PPE) use during sterile compounding; rules around detailed information sharing for discharge planning; certain medical record requirements; telehealth limitations among CAHs; and several others. The full list for these provider types ends at p. 7.
End-Stage Renal Disease (ESRD) Facilities *(p. 14)*	CMS waives requirements related to training programs and periodic audits; emergency preparedness; frequency requirements for some patient assessments; time period for initiating care planning and monthly physician visits; dialysis home visits for monitoring patient adaptation to home dialysis; expanding the designation for special purpose renal dialysis facilities (SPRDFs); expanding ESRD care to patients in nursing homes; and, more.
Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs) *(p. 9)*	Includes waivers for the 3-day prior hospitalization requirement; timeframe requirements for submitting Minimum Data Set assessments and transmissions; resident group requirements; in-person visit requirements for physicians and practitioners, now allowing them to be conducted via telehealth; resident transfer and discharge requirements; and more. The full list concludes on p. 12.
Inpatient Rehabilitative Facilities (IRFs) and Inpatient Psychiatric Facilities (IPFs) and Providers *(p. 7-8)*	o Waivers allowing acute care hospitals to house acute care inpatients in excluded distinct part units. o Waivers allowing acute care hospitals to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. o Waivers allowing acute care hospitals to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. o Waives the 60 percent rule requirement for IRFs associated with requirements to receive payment.
Long-Term Care Acute Hospitals (LTCHs) *(p. 9)*	Allows LTCHs to exclude patient stays related to the COVID-19 pandemic from the 25-day average length of stay requirement.
Home Health Agencies (HHAs) *(p. 12)*	See the list of HHA waivers on p. 12-13.
Hospice *(p. 13)*	See the list of hospice waivers on p. 13.

Neoplastic Disease Care Hospitals *(p. 9)*	Allows extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which affects how the hospital is paid.
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) *(p. 16*)	CMS is allowing Medicare Administrative Contractors (MACs) to waive replacement requirements for DMEPOS that is lost, destroyed, irreparably damaged, or otherwise unusable. Such waivable requirements include the face-to-face requirement, a new physician's order, and new medical necessity documentation.

CMS is also extending the deadline for the inpatient prospective payment system (IPPS) wage index occupational mix survey submission. See p. 8. Additional, broader waivers and information on pertinent legal background begins on p. 17.

CMS has also made available provider- and stakeholder-specific fact sheets that detail all relevant and applicable waivers and flexibilities. See below.

- Physicians and Other Practitioners (PDF)
- Ambulances (PDF)
- Hospitals (PDF)
- Teaching Hospitals, Teaching Physicians and Medical Residents (PDF)
- Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities) (PDF)
- Home Health Agencies (PDF)
- Hospices (PDF)
- Inpatient Rehabilitation Facilities (PDF)
- Long Term Care Hospitals & Extended Neoplastic Disease Care Hospitals (PDF)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (PDF)
- Laboratories (PDF)
- End Stage Renal Disease (ESRD) Facilities (PDF)
- Durable Medical Equipment (PDF)
- Participants in the Medicare Diabetes Prevention Program (PDF)
- Medicare Advantage and Part D Plans (PDF)

II. Details on each provision in the IFC (here) follow.

- **Payment for Medicare Telehealth Services Under Section 1834(m) of the Act** – Beginning on p. 11, CMS modifies payment for telehealth services in the following key ways:
    - CMS will reimburse providers billing for telehealth according to the payments they would have received had they furnished the services in-person, including by incorporating the "facility fee" costs based on the facility in which the provider furnishes the telehealth service. For example, as CMS includes, a physician that normally treats

patients in an outpatient hospital clinic would receive the facility rate for services furnished via telehealth. CMS instructs all practitioners to report the POS code that they would normally report when billing for an in-person service when furnishing a service via telehealth during the public health emergency. See p. 13 of the IFC for more. See p. 13 for more.

- CMS will also temporarily include many new services to the list of eligible Medicare telehealth services. The list of temporarily added services begins on p. 19 of the IFC, and includes codes for emergency department visits, observation services, nursing facility visits, home visits, inpatient neonatal and pediatric critical care, end-stage renal disease (ESRD) services, and more.

- **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** –Beginning on p. 41, CMS states that it is removing the frequency restrictions that would otherwise exist for services on the Medicare telehealth list (such restrictions ensured the services met the telehealth category 1 or 2 criteria). The codes for which this applies are for subsequent inpatient visits and nursing facility visits. The list begins on p. 42.

  CMS also states it is lifting the once-per-day restriction on critical care consultations delivered via telehealth.

  CMS is allowing the clinical examination of the vascular access site for end-stage renal disease (ESRD)-related services to be delivered via telehealth, temporarily lifting the face-to-face "hands on" requirement generally in place. See p. 45 for more.

- **Telehealth Modalities and Cost-sharing** – On p. 48, CMS adds a temporary exception clarifying that mobile phones with audio and visual capabilities qualifies as an "interactive telecommunications system" for the purposes of telehealth.

  On p. 49, CMS states that physicians and other practitioners will not be subject to penalties for reducing or waiving cost-sharing for telehealth services for any Federal health care program beneficiaries. This is in reference to the Office of Inspector General (OIG)'s Policy Statement on the same issue. CMS further notes that this applies to a variety of "non-face-to-face" care modalities, including: telehealth visits, virtual check-in services, e-visits, remote care management, and monthly remote patient monitoring.

- **Communication Technology-Based Services** – Communication technology-based services (CTBS) services are services that use telecommunications technology but are not considered Medicare telehealth services, including certain kinds of remote patient monitoring, and remote interpretations of diagnostic tests.

  Beginning on p. 50, CMS states that providers can furnish all CTBS to both new and established patients.

  CMS also clarifies that auxiliary staff under general supervision can document consent to receive these services. While consent must be obtained annually, it may be obtained at the same time that a CTBS service is furnished.

CMS clarifies on p. 54 that licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can bill HCPCS codes G2061-G2063. CMS further rules that, temporarily, such provider types can bill for HCPCS codes G2010 and G2012, which describe remote evaluation of patient/images video and virtual check-ins. CMS notes this list "is not exhaustive" and seeks additional input on other practitioners who might furnish these services during the COVID-19 pandemic.

- **Direct Supervision by Interactive Telecommunications Technology** – On p. 57, CMS states it is temporarily revising the definition of "direct supervision" to allow it to be provided using real-time interactive audio and video technology. CMS seeks input on whether it should implement any guardrails for this change and whether it poses any risk for beneficiaries. CMS further notes on p. 59 that it is adopting similar changes for direct supervision of diagnostic services furnished directly or "under arrangement in the hospital or in an on-campus or off-campus outpatient hospital department."

- **Clarification of Homebound Status under the Medicare Home Health Benefit** – On p. 61, CMS states it will consider a beneficiary as "homebound" during the COVID-19 pandemic if (1) a physician has determined a beneficiary should not leave the home because of confirmed or suspected COVID-19; or (2) a physician has determined a beneficiary should not leave the home due to the high risk of contracting COVID-19. This designation will make such beneficiaries eligible to receive the Medicare Home Health Benefit.

  CMS briefly provides guidance for recording the homebound determination in the beneficiary's medical record.

  CMS further clarifies that, beyond the designation as homebound, a beneficiary must meet other home health eligibility requirements to receive home health services under Medicare. See p. 63. Also see the dedicated fact sheet here.

- **The use of Telecommunications Technology Under the Medicare Home Health Benefit During the PHE for COVID-19 Pandemic** – CMS notes that, while it remains statutorily prohibited from allowing a telehealth visit to substitute for a home health in-person visit, it will now allow home health providers to furnish a more expansive set of telecommunication system-based services in conjunction with in-person visits. See p. 65. CMS further explains that use of such services must be in alignment with the beneficiary's home health plan of care, including a description of how the use of such services will achieve the care plan goals without substituting for an in-person visit. More detail is on p. 72. Also see the dedicated fact sheet here.

- **The use of Technology under the Medicare Hospice Benefit** – CMS will permit hospice providers to furnish telehealth for beneficiaries receiving routine home care if it is feasible and appropriate to do so to ensure Medicare beneficiaries can continue receiving services that are reasonable and necessary. CMS specifies that the use of telehealth must be included in the plan of care and must be tied to patient specific needs. See p. 73 for more. Also see the dedicated fact sheet here.

- **Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement** – Face-to-face visits are required for recertification of Medicare hospice services that are anticipated to reach the third benefit period as well as each benefit period thereafter. Since the visits serve an administrative purpose, CMS is allowing them to be performed using telecommunications technology during the public health emergency for the COVID-19 pandemic. CMS is including

the use of multimedia communications equipment that has, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site hospice physician or hospice in its definition of "telecommunications technology." Telehealth visits for the purpose of recertification will be considered an administrative expense and should not be separately billed. Also see the dedicated fact sheet here.

- **Modification of the Inpatient Rehabilitation Facility Face-to-Face Requirement** – Typically, for payment of inpatient rehabilitation facility (IRF) claims, CMS requires patients to receive face-to-face visits with a rehabilitation physician at least 3 days a week throughout their stay. During the public health emergency for the COVID-19 pandemic, CMS will allow the face-to-face visit requirements to be met via telehealth to protect Medicare beneficiaries and the rehabilitation physicians treating them. The post-admission physician evaluation can count as one of the face-to-face visits. See more in the dedicated fact sheet here.

- **Removal of the IRF Post-Admission Physician Evaluation Requirement** –To provide rehabilitation physicians with as much flexibility as possible and to limit time spent on paperwork, CMS is removing the post-admission physician evaluation requirement for all IRFs during the public health emergency for the COVID-19 pandemic.

- **Rural Health Clinics and Federally Qualified Health Centers** – CMS is expanding, on an interim basis, the services that can be included in the payment for HCPCS code G0071, and is updating the payment rate to reflect the addition of these services. Specifically, CMS is adding the following three CPT codes:

    - **99421** (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes);
    - **99422** (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes); and
    - **99423** (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes).

  The agency is also revising the payment rate for HCPCS code G0071 to be the average of the PFS national non-facility payment rate for HCPCS code G2012 (communication technology-based services), HCPCS code G2010 (remote evaluation services), CPT code 99421, CPT code 99422, and CPT code 99423. Rates are effective for services furnished on or after March 1, 2020 and throughout the PHE for the COVID pandemic.

  CMS is making all virtual communication services billable using HCPCS code G0071 available to new patients. The agency is also removing the requirement to obtain prior beneficiary consent when it would interfere with the timely provision of these or the monthly care management services. Under the new flexibilities, consent must be obtained before the services are billed and can now also be acquired by staff under the general supervision of the rural health clinic (RHC) or federally qualified health center (FQHC) practitioner. See more in the dedicated fact sheet here.

- **Medicare Clinical Laboratory Fee Schedule** – CMS will provide a nominal specimen collection fee and associated travel allowance to independent laboratories for collection of specimens related to COVID-19 clinical diagnostic laboratory testing for homebound and non-hospital inpatients.

Importantly, CMS defines "homebound" to mean a patient is medically contraindicated to leave the home. A patient exercising "self-quarantine" for their own safety, would not automatically be considered "homebound" unless it is also medically contraindicated for the patient to leave the home.

The nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be $23.46 (billed to G2023) and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of a home health agency (HHA) will be $25.46 (billed to G2024). Medicare-enrolled independent laboratories can bill for the travel allowance with the current HCPCS codes P9603 (per mile) and P9604 (flat rate). See the dedicated fact sheet here.

- **Requirements for Opioid Treatment Programs –** CMS will temporarily waive the requirement that Opioid Treatment Programs furnish the counseling and therapy components of the weekly bundle of services using two-way interactive audio/video communication technology. During the COVID-19 pandemic, OTPs will be allowed to furnish and bill for counseling and therapy – as part of the weekly bundle of services and via the add-on code for additional counseling or therapy – using audio-only telephone calls if the beneficiary lacks access to two-way audio/video communication technology, provided all other applicable requirements are satisfied. See p. 101 for more details.

- **Application of Teaching Physician and Moonlighting Regulations –** CMS revises several regulations to expand the physician workforce to meet the increasing needs of the COVID-19 pandemic. First, CMS amends the requirement for a teaching physician to be physically present when a resident furnishes certain services by allowing the teaching physician to directly supervise the resident via real-time, audio and video telecommunications technology. This flexibility applies to all levels of an office/outpatient E/M service furnished in primary care centers, interpretation of diagnostic radiology and other diagnostic tests, and psychiatric services. Of note, teaching physician must be physically present for surgical, high-risk, or other complex procedures; procedures performed using an endoscope; and anesthesia services.

  Second, regarding telehealth services, CMS will temporarily allow a teaching physician to bill Medicare for services furnished by a resident via telehealth. CMS also allows a teaching physician to directly supervise the resident furnishing telehealth service using real-time, audio and video telecommunications technology. In addition, CMS allows a resident under quarantine to furnish service via telehealth, provided the teaching physician directly supervises the resident using interactive telecommunications technology.

  Last, regarding moonlight regulations, CMS will temporarily allow Medicare to be separately billed for services furnished by a resident in the inpatient hospital setting that are not related to their approved GME program.

  CMS seeks comments on whether other procedures should be exempt from the flexibility due to their complexity or patient risk. Additionally, the agency seeks comments on whether the use of interactive telecommunication technology is appropriate for a public health emergency and if any guardrails should be included. See discussion on pp. 101-109 for more information.

- **Special Requirements for Psychiatric Hospitals –** CMS revises the Psychiatric Hospital Conditions of Participation (CoP) regarding which hospital personnel may be allowed to record progress notes of psychiatric patients. Specifically, CMS allows non-physician practitioners

(NPPS) and advance practice providers (APPs) in the psychiatric hospital setting to complete progress notes of patients for whom they are responsible. This change is intended to expand the psychiatric care workforce. See pp. 110-114 for more details.

- **Innovation Center Models** – CMS modifies several innovation center models in response to the COVID-19 pandemic. CMS will allow certain beneficiaries to obtain the set of Medicare Diabetes Prevention Program (MDPP) more than once per lifetime, increase the number of virtual make-up sessions, and temporarily permit certain MDPP suppliers to virtually deliver MDPP sessions. See pp. 114-116. Also see the dedicated fact sheet here.

  The agency will extend the Comprehensive Care for Joint Replacement (CJR) model through March 31, 2021, which was scheduled to end on December 31, 2020. In addition, CMS will extend the "extreme and uncontrollable circumstances policy" (i.e., financial safeguards) to certain participating hospitals located in areas heavily affected by COVID-19. See pp. 116-119.

  CMS is considering future rulemaking, including another interim final rule, to modify or suspend Alternative Payment Model (APM) Quality Payment Program (QPP) policies in response to COVID-19. See p. 119.

- **Remote Physiologic Monitoring** – CMS will temporarily allow remote physiologic monitoring (RPM) services to be furnished to both new patients as well as to existing patients. In addition, CMS will allow verbal consent for RPM services to be obtained once annually, including at the time services are furnished, for the COVID-19 public health emergency, instead of requiring consent each time services are furnished. Last, CMS states that RPM codes can be used to monitor patients with acute and/or chronic conditions, including "a patient with an acute respiratory virus" (i.e., COVID-19). See p. 119-122 for more information.

- **Telephone E/M Services** – CMS allows providers to temporarily furnish certain evaluation and management (E/M) services (CPT codes 98966-98968 and CPT codes 99441-99443) to beneficiaries through telephone (i.e., audio-only) communications during the public health emergency for COVID-19 pandemic. CMS also outlines billing modifications regarding practitioners performing these services, and relaxes enforcement of some of the code descriptors for these services to ensure that these services can be extended to both new and established patients. See pp. 121-125.

- **Physician Supervision Flexibility for Outpatient Hospitals** – To ensure that hospitals have as much flexibility as possible during this time, CMS changes the minimum default level of supervision to general supervision for all outpatient hospital therapeutic services – i.e., non-surgical extended duration therapeutic services (NSEDTS) – during the initiation of the service. Pursuant to CMS regulations, "general supervision" means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. See pp. 126-127. Also see the dedicated fact sheet here.

- **Application of Certain NCD and LCD Requirements** – CMS outlines a number of temporary flexibilities during the public health emergency for COVID-19 pertaining to the implementation of National Coverage Determination (NCD) and Local Coverage Determination (LCD) requirements. These include a temporary waiver of certain NCD or LCD requirements stipulating a face-to-face (F2F) or in-person encounter for evaluations, assessments, certifications or other implied F2F requirements. CMS also outlines flexibilities regarding NCD or LCD requirements

for consultations or services furnished by or with the supervision of a particular medical practitioner or specialist. See pp. 127-129.

- **Counting of Resident Time –** This provision, detailed on p. 137 (section II.X), permits a hospital to claim – for the duration of the PHE – a resident for indirect medical education (IME) and direct graduate medical education (DGME) for the time that the resident is performing patient care activities within the scope of his/her approved program in his or her own home, or in a patient's home. The patient care activities must still be performed pursuant to physician supervision requirements, which have been modified by the IFC to include either direct supervision (i.e., physical presence) or supervision via interactive technology, including when a medical resident is quarantined at home (section II.O). For further details on the **new flexibilities extended to teaching hospitals**, please see here.

- **Change to MSSP Extreme and Uncontrollable Circumstances Policy –** CMS will extend the 2019 Merit-based Incentive Program System (MIPS) data submission deadline until April 30, 2020, to allow clinicians more time to report quality data This deadline extension also applies to Shared Savings Program Accountable Care Organizations (ACOs). CMS acknowledges that the extension may not be sufficient enough to ease the reporting burden, and also extends the extreme and uncontrollable circumstances policy to MIPS eligible clinicians who do not submit their MIPS data by the extended deadline. See p. 131 for more.

- **Level Selection for Office/Outpatient E/M Visits –** On an interim basis, CMS is revising its policy to specify that office/outpatient E/M level selection for telehealth services can be based on MDM or time, with time defined as all the time associated with the E/M on the day of the encounter. See p. 136 for more.

- **Addressing the Impact of COVID-19 on Part C and Part D Quality Rating Systems –** CMS will modify the 2021 and 2022 Part C and D Star Ratings to account for data collection disruptions and distortions to measure scores resulting from the COVID-19 outbreak. Details on the changes to the calculation can be found on p. 144 and 145. More information is also included in the dedicated fact sheet here.

- **Changes to Expand Workforce Capacity for Ordering Medicaid Home Health Services, Medical Equipment, Supplies and Appliances and Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services –** Beginning on p. 159, CMS will allow licensed practitioners practicing within their scope of practice, such as, but not limited to, nurse practitioners (NPs) and physician assistants (PAs), to order home health services during the public health emergency. This change also applies to who can order medical supplies, equipment and appliances and physical therapy, occupational therapy, or speech pathology and audiology for Medicaid beneficiaries.

- **Origin and Destination Requirements under the Ambulance Fee Schedule –** CMS will allow ambulances to transport patients from any point of origin to additional destinations, including community mental health centers, federally qualified health centers, physician offices, urgent care centers, ASCs, and any locations that furnish dialysis services when an ESRD facility is not available. The expanded list applies to medically necessary emergency and non-emergency ground ambulance transports of beneficiaries during the public health emergency. See p. 162. See the dedicated ambulance provider fact sheet here.

- **Merit-based Incentive Payment System (MIPS) Updates –** CMS adds one new MIPS Improvement Activity for the CY 2020 performance period addressing response to the public health emergency through participation in a COVID-19 clinical trial of a drug or biologic treating the infection. See Table 1 on p. 165.

  The agency also applies the MIPS automatic extreme and uncontrollable circumstances policy for the 2019 performance policy. Among other changes, CMS also extends the deadline for submitting an application for reweighting the quality, cost, and improvement activities categories based on extreme and uncontrollable circumstances and the Promoting Interoperability category. The deadline is now April 30, 2020 for applications demonstrating they have been adversely impacted by the pandemic. See p. 165-166 for details.

- **Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital (i.e., Hospital without Walls) –** Effective for discharges after March 1, 2020, CMS will allow hospitals to furnish inpatient services, including routine services such as room and board and nursing, while still receiving hospital payments from CMS. Hospitals still have to exercise "sufficient control and responsibility over the use of hospital resources" in treating these patients.

  As noted in the fact sheet, these outside temporary expansion sites may include ambulatory surgical centers, inpatient rehabilitation hospitals, hotels, and dormitories. CMS provides the specific example where a hospital can leverage a hotel to care for patients needing less intensive care while reserving inpatient beds for COVID-19 patients. See a discussion beginning on p. 167 of the public inspection copy and more details in a hospital-specific fact sheet here.

- **Advance Payments to Suppliers Furnishing Items and Services under Part B –** Beginning on p. 173, CMS makes changes to the agency's ability to make advance payments if a contractor cannot process payments within established time limits. Among other changes, CMS raises the advance-payment limit to 100 percent of the anticipated payment for a claim based on the historical assigned claims payment data for claims paid to the supplier. The limit was previously 80 percent.

III. Additional Information (for health plans and State Surveyors)

- CMS also provided a memo to all Medicare Advantage (MA) organizations, Part D sponsors, Medicare-Medicaid plans, and all Programs of All-inclusive Care for the Elderly (PACE) organizations on the reprioritization of risk adjustment data validation (RADV) audit activities. CMS notes that while oversight of these organizations will continue, priority has been shifted to the investigation and resolution of: 1) instances of noncompliance where the health and safety of beneficiaries are at serious risk; and 2) complaints alleging infection control problems, including COVID-19 or other respiratory illnesses. Effective immediately, CMS is also suspending RADV activities related to the payment year 2015 audit and will not initiate any additional contract-level audits until the public health emergency concludes.

- Effective March 4, 2020, CMS is suspending non-emergency survey inspections across the country. Instead, inspectors will focus on the most serious health and safety threats such as infectious diseases (including the spread of COVID-19) and abuse.

  CMS urges State Survey Agencies (SAs), Accrediting Organizations (AOs), and healthcare facilities, to remain compliant with current CMS requirements and safety standards, particularly those related to infection control. Certified providers and suppliers should monitor the Centers for

Disease Prevention and Control (CDC) COVID-19 website as well as their state's public health website and follow recommended guidelines and acceptable standards of practice. All recently issued COVID-19 guidance for SAs and AOs can be found here.