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The CARES Act *Hot Topics for Health Care Providers*

Introduction:

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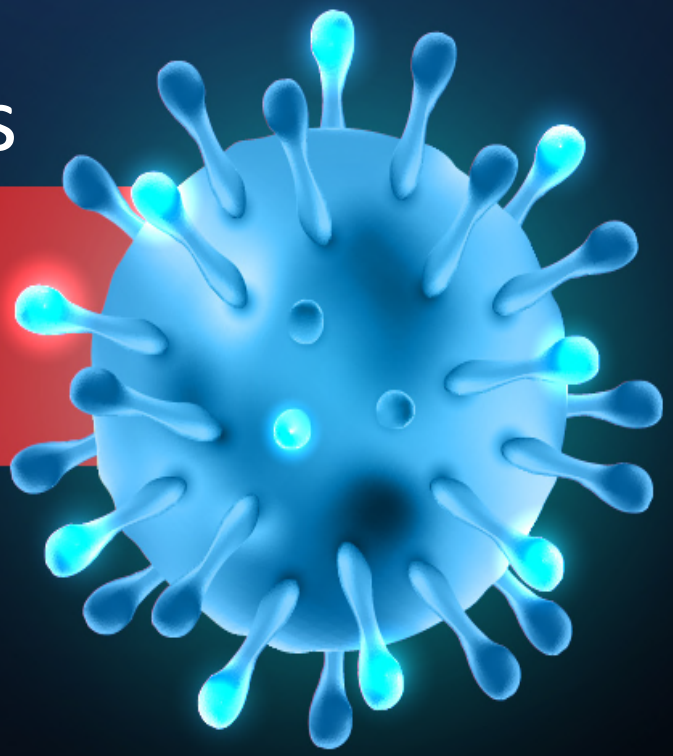
Coronavirus COVID-19

Updates and Resources



For links to guidance from various state and federal agencies regarding COVID-19 go to http://www.health-law.com/newsroom-news-166.html

Agenda

The CARES Act (Pub. L. 116-136):

- How Congress Got There, and What's Next
- Provider Reimbursement and Relief
- COVID-19 and Telehealth
- Privacy Provisions

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The CARES Act: How Congress Got There, and What's Next

Congressional Action in March on COVID-19

Signed into Law on March 6: The Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074)

- Provided $8.3 billion in emergency funding
- Included telehealth waivers

Signed into Law on March 18: The Family First Coronavirus Response Act (H.R. 6201)

- No cost coverage of COVID-19 testing
- Paid Sick Leave, FMLA, etc.

Signed into Law on March 27: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (H.R. 748)

Key CARES Act Provisions

- Providing $100 billion in funding to hospitals and providers;
- Temporarily lifting the Medicare sequester through December 31, 2020;
- Creating a 20% Medicare add-on payment for inpatient hospital COVID-19 patients;
- Allowing flexibility for acute care hospitals to transfer patients out of their facilities and into alternative care settings in order to prioritize resources;
- Aligning the 42 CFR Part 2 regulations on confidentiality and sharing of substance use disorder treatment records with HIPAA;
- Supporting provisions for the health care workforce; and
- Further expanding the use of telehealth.

COVID-19 Stimulus Package #4?

- *"Our first bills were about addressing the emergency. The third bill was about mitigation. The fourth bill would be about recovery. Emergency, mitigation, recovery,"* – House Speaker Nancy Pelosi
- Examples of Health Care Provisions
  - Insurance Coverage/Cost
  - Protection of Frontline Health Care Workers
  - Mental Health
  - Surprise Billing
  - Rx Drug Pricing
- Examples of Non-Health Care Provisions
- Timing & How it Becomes Bi-Partisan

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The CARES Act: Provider Reimbursement and Relief

$100B for COVID-19 Expenses/Losses

- $100 Billion appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) for providers
- Purposes:
  - COVID-19 health expenses
  - Lost revenue attributable to COVID-19
- Eligible providers?
  - Public entities
  - Medicare/Medicaid enrolled suppliers/providers
  - For-profit and not-for-profit entities specified by HHS that provide COVID-19 diagnosis, testing, or care
- Will be Administered by HHS
  - May be pre-payment, prospective payment, or retrospective payment
  - Consider most efficient payment systems practicable
  - Application includes statement justifying need and TIN
  - Can't reimburse expenses or losses that other sources are obligated to reimburse

Temporary Sequester Relief

Medicare Sequester:

- 2% reduction to FFS Medicare Payments
- In place since April 1, 2013

CARES Act:

- Exempts Medicare from sequestration from May 1, 2020 to December 31, 2020
- Extends sequester from 2029 to 2030

→ Consider impact on Medicare Advantage payments

Accelerated & Advance Payments Program

Eligibility:

- Billed Medicare for claims within 180 days immediately prior to request
- Not in bankruptcy
- Not under active medical review or program integrity investigation
- No outstanding, delinquent Medicare overpayments

Application Process

- Use existing MAC applications, links available at our COVID-19 Resource page
- CMS Fact Sheet gives specific instructions: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

AMOUNT ADVANCED:

- **Hospitals: 6-months of Medicare payments**
- **Others: 3-months of Medicare Payments**

TIMING:

- **Processing: 7 days**
- **Repayment begins after 120 days**
- **Balance due after 1 year (hospitals) or 210 days (others**

Medicare IPPS Add-On Payment

- Recognition that COVID-19 inpatients are more costly than others:
  - More intensive services
  - Longer length of stay
- DRG weight increased by 20% for individuals diagnosed with COVID-19
- 20% add-on applies for discharges during the Public Health Emergency (beginning January 27, 2020)
- New COVID-19 Diagnosis Code: U07.1

COVID-19 Testing & Payment

- Families First Coronavirus Relief Act (FFCRA):
  - Medicare/Medicaid FFS & MA:
    - Coverage without cost-sharing for COVID-19 testing-related service, including the E/M visit
  - Commercial Plans:
    - Coverage without cost-sharing, prior authorization, etc. for COVID-19 testing
    - Includes items and service furnished during office, urgent care, and emergency room visits but only to the extent such items and services relate to the furnishing or administration of the test or evaluation for purposes of determining the need for such test
- CARES Act—Commercial Reimbursement & Cash Price Requirement
  - COVID-19 reimbursement:
    - Negotiated rate in effect in January (if any)
    - If no negotiated rate, cash price or lower negotiated rate
  - Price Transparency:
    - Provider must publicize “cash price” for COVID-19 test on its public internet website
    - Compliance enforced through corrective action plans and then CMP of up to $300/day

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COVID-19 and Telehealth

CARES ACT and Telehealth

1. Providers can now use audio-only communication to furnish telehealth services.
2. No pre-existing practitioner-patient relationship is required.
3. FQHCs and RHCs – not just providers at such facilities – can bill for telehealth services, as appropriate.
4. Monthly in-person visit requirement for ESRD patients is waived.
5. Hospice eligibility recertification can be performed via telehealth.
6. Additional HRSA funding is available for facilities who want to expand their telehealth offerings.

COVID-19, Medicare and Telehealth

1. The patient must be located at an approved “originating site” facility;

   → *Waived. FFS beneficiaries can be located anywhere, including the home.*

2. The originating site facility must be in a rural health professional shortage area (HPSA), unless an exception applies;

   → *Waived.*

3. The service must be a “Medicare telehealth service”;

   → *CMS has added 80 more services to the “Medicare telehealth services” list.*

4. The service must be provided by an approved category of provider;→

   → *Largely in place, but the requirement that the provider be licensed in the state where the patient is located is waiving for purposes of Medicare and Medicaid reimbursement.*

5. The service must be rendered via synchronous audio-video technology.

   → *Waived. Through the CARES Act, consults by telephone are acceptable where audio-video communication isn’t possible.*

COVID-19 and Medicare Billing for Telehealth

"Medicare Telehealth Services" should be billed with the 95 modifier, and place of service (POS) 02, indicating that the service was provided via telehealth.

For non- "Medicare telehealth services," bill with the POS which *would have applied,* and the 95 modifier.

COVID-19 and Telehealth Beyond Medicare: Licensure

When treating a patient via telehealth, the provider must be licensed in the state where the patient is located. CMS has waived for purposes of Medicare and Medicaid reimbursement, however *state law still applies.*

Some states have waived licensure requirements in response to COVID-19.

- In California, physicians licensed in other states but not in California can treat California patients, as long as the facility with which they are working has received approval from California's Emergency Medical Services Authority.
- In Massachusetts, Gov. Baker issued an order calling for out-of-state physicians to be granted emergency licenses to treat Massachusetts patients.

COVID-19 and Telehealth Beyond Medicare: Coverage and Reimbursement

There is tremendous variation among the states regarding telehealth parity, both concerning *coverage* and *payment.*

Like licensure, many states have made temporary exceptions in response to COVID-19.

California's DMHC has issued an All Plan Letter (APL) calling for plans to cover telehealth services, and pay for them at the same level as they would if the services were provided in-person.

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The CARES Act: Privacy Provisions

Confidentiality and Disclosure of SUD Records

Section 3221 substantially revises the federal substance use disorder (SUD) statute (42 U.S.C. § 290dd-2), which underpins the federal SUD confidentiality regulations (42 CFR Part 2, aka Part 2). In particular, the law aligns certain Part 2 requirements with HIPAA and its implementing regulations.

- *Reminder*: Part 2 applies to federally-assisted programs that provide substance use disorder, treatment, and referral services.
- Changes take effect March 2021.
- SAMHSA to issue implementing regulations that will flesh out updates and provide more clarity on changes.

Confidentiality and Disclosure of SUD Records

Section 3221 partially aligns Part 2 with HIPAA in a number of ways:

1. **Consent**
   - Once a patient gives one time written consent, a Part 2 program may use or disclose the contents of a record for all future treatment, payment, and health care operations as permitted by HIPAA.
   - Redisclosures can be made in accordance with HIPAA, unless patient revokes (keeping in mind state law restrictions on disclosure).

2. **Breach notification and notice of privacy practices**
   - Part 2 programs will need to comply with HIPAA breach notification and notice of privacy practice requirements.

3. **Penalties**
   - Makes statutory civil and criminal penalties that apply to violations of HIPAA applicable to violations of Part 2.

Confidentiality and Disclosure of SUD Records

Other key changes and takeaways under Section 3221:

1. **Antidiscrimination**
   - Introduces a broad prohibition discrimination on basis of Part 2 information against a patient regarding admission/access/treatment for health care, employment, housing, access to courts, or the provision of government benefits.

2. **Use in proceedings**.
   - Confirms the prohibition on the disclosure of Part 2 information for criminal proceedings extends to civil, administrative and legislative proceedings (still need a compliant court order or patient consent to disclose).

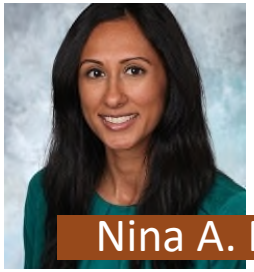
3. **Deidentified SUD info**
   - The provision also clarifies that, if SUD information is de-identified, it may be disclosed to public health authorities without patient consent.

Guidance on Protected Health Information

Section 3224

- Requires HHS to issue guidance on the sharing of protected health information under HIPAA during the COVID-19 public health emergency within 180 days of enactment.
- The legislation does not provide any details on what such guidance should say.
- *Note*: HHS has already waived certain HIPAA requirements for hospitals operating under disaster protocols and for providers engaging in telehealth.

Questions



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