BAKER NEWMAN NOYES

BNN Healthcare Advisory Group COVID-19 Client Communication

H.R. 748
An Act to Amend the Internal Revenue Code of 1986 to Repeal the Excise Tax on High Cost Employer-Sponsored Health Coverage

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
Enacted March 27, 2020

Summary of Sections Relevant to Healthcare Providers

March 31, 2020

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THE CARES ACT: A SUMMARY OF SECTIONS RELEVANT TO HEALTHCARE PROVIDERS

BAKER NEWMAN NOYES

THOUGHT LEADERSHIP

March 31, 2020

On Friday, March 27, the President signed into law the 880-page *Coronavirus Aid, Relief, and Economic Security Act* ("CARES Act). This was the third phase of major federal legislation created in response to the COVID-19 pandemic. It was preceded by the *Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020*, which set in motion funding for various government agencies; and the *Families First Coronavirus Response Act*.

Our healthcare advisory group has been sharing regular industry updates and news related to COVID-19 developments. They can all be found in our COVID-19 Resource Center. The resource center is continually being populated with articles from all of BNN's practice groups. The purpose of this publication is to share and summary and BNN's insights into the features of the CARES Act that are applicable to the healthcare industry.

If you would like to discuss these matters further, please contact a member of our healthcare advisory group via email or at 800.244.7444.

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PART II: ACCESS TO HEALTHCARE FOR COVID-19 PATIENTS

Subpart A – Coverage of Testing and Preventive Services

SECTIONS 3201, 3202 & 3203: THE CARES ACT-DIAGNOSTIC TESTS, VACCINES AND PREVENTIVE MEASURES FOR COVID-19

These sections of the CARES Act require health plans and insurers to cover diagnostic laboratory tests for COVID-19 and certain vaccines and preventive measures. Reimbursement to the test provider shall be at pre-emergency negotiated rates. In the absence of the negotiated rate, reimbursement shall be equal to the cash price for services published on a publicly-available website. Providers of laboratory tests for COVID-19 are required to publish a cash price for diagnostic testing. Providers may potentially face civil monetary penalties for failure to publicize cash prices for diagnostic tests for COVID-19.

Requires health plans and insurers to cover, without cost-sharing for the beneficiary, any qualifying COVID-19 preventive service, defined as an item, service, or immunization intended to prevent or mitigate COVID-19-and vaccines for coronavirus.

Key Takeaways:

- Insurers required to cover diagnostic laboratory tests for COVID-19
- Reimbursement at pre-emergency negotiated rates
- Providers of lab tests required to publish cash price

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Subpart B – Support for Healthcare Providers

SECTION 3211: SUPPLEMENTAL AWARDS FOR HEALTH CENTERS

The term “health center” means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements, required primary health services, and additional health services necessary for the adequate support of the primary health services, for all residents of the area being served by the health center.

Section 3211 provides an additional $1.32 Billion in funding to health centers on the front lines for the detection of SARS-Cov-2, or the prevention, diagnosis and treatment of COVID-19. Here is a link to a press release from the U.S. Department of Health and Human Services (HHS) discussing awards.

Click here to see a listing of awards by state and specifically which health centers are receiving awards.

Key Takeaways:

- Provides additional $1.32 Billion in funding to health centers for the detection of SARS-Cov-2, or the prevention, diagnosis and treatment of COVID-19
- Running list of providers receiving this funding

SECTION 3212: TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS

The following includes provisions to expand the Health Resources and Services Administration (HRSA) authority to use Section 1135 waivers in a way that extends the waivers to providers of telehealth services, to permit Medicare payment for telehealth services delivered by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) during emergency periods (emergency or disaster declared by the President pursuant to the National Emergencies Act, and a public health emergency is declared by the Secretary of HHS) and to relax criteria for eligibility for telehealth network and resource center grant programs.

Telehealth offers flexibility for patients with, or at risk of contracting, COVID-19 to access screening or monitoring care while avoiding exposure to others. The grant program has been modified to encourage new types of grantees to apply, particularly if they already have the types of equipment that can quickly improve patient access.

Section 3212 updates include:

- Services to include substance use disorders
- Rural areas in addition to medically underserved areas
- Extended grant periods from four to five years
- Removal of caps on maximum grant amounts
- Decrease in the allowable proportion of grant funds to be spent on equipment from 40% to 20%
- For-profit entities to apply for grants
- Authorized appropriation of $29 million for each fiscal year 2021 through 2025 to fund telehealth network and telehealth resource center grants

Key Takeaways:

- Grant program has been modified to encourage new types of grantees to apply
- Improves patient access
- Removal of grant caps
- For-profit entities now allowed to apply for grants
- $29 million appropriated (each year) for FY 2021-2025 to fund grants

SECTION 3213: RURAL HEALTHCARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, AND SMALL HEALTHCARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS

Summary:

Section 3213 amended Section 330A of the Public Health Service Act (42 U.S.C. 254c). The grant programs within Section 3213 will be administered by the Director of the Office of Rural Health Policy of HRSA in coordination with State offices or government entities. These grants may be awarded to expand access, coordinate and improve quality of services, and enhance the delivery of care in rural areas.

General Purpose:

The purpose of this section is to provide guidelines around three types of grants for the following uses:

1. **Expanding delivery of healthcare services in rural areas:**
    - Eligible entities may be awarded grants by improving and expanding delivery to include new and enhanced services in rural areas utilizing evidence-based or

innovative, evidence-driven models. A key change within these grants is the extension of the award period from a maximum of three years, to five years.

- To be considered eligible for these grants, an entity must have demonstrated experience serving or have the capacity to serve rural underserved populations, and represent a consortium (at least 3 healthcare providers, can also include nonprofit and for-profit entities and has not previously received a grant under this section for the same/similar project, unless the entity is expanding the scope of the project or area that will be served).
- In consultation with appropriate State offices or entities, applying entities should prepare an application including information such as: a description of the project and how funds will be used, a description of how the project will meet the healthcare needs of rural underserved populations, a description of how the community or region being served will be involved in the ongoing development and plans to sustain beyond Federal support.

2. **Planning and implementation of integrated healthcare networks in rural areas:**
    - Eligible entities may be awarded grants to plan, develop, and implement integrated healthcare networks that collaborate in order to achieve efficiencies, expand access and improve the quality of basic healthcare services, and strengthen the rural care system as a whole. A key change within these grants is the extension of the award period from a maximum of three years, to five years.
    - To be considered eligible for these grants, an entity must have demonstrated experience serving or have the capacity to serve rural underserved populations, representing a consortium (at least three healthcare providers, can also include nonprofit and for-profit entities and has not previously received a grant under this section for the same/similar project).
    - In consultation with appropriate State offices or entities, applying entities should prepare an application including information such as: a description of the project and how funds will be used, an explanation of why Federal assistance is required to carry out the project, a description of the group's history of collaboration, how the rural underserved communities will benefit from being involved, a description of how the communities will experience increased access to quality services as a result of the network, and a plan for how the project will be sustained beyond Federal funding.
3. **Planning and implementation of small healthcare provider quality improvement activities:**
    - Eligible entities may be awarded grants to aid in the planning and implementation of quality improvement activities, including activities related to increased care coordination, enhancing chronic disease management, and improving health outcomes. A key change in these grants is the extension of the award period from a maximum of three years, to five years.
    - To be considered eligible for these grants, an entity must be a rural public or rural nonprofit healthcare provider such as a critical access hospital or rural health clinic and must not have previously received a grant under this section for the same/similar project.
    - In consultation with appropriate State offices or entities, applying entities should prepare an application including information such as: a description of the project and how funds will be used, an explanation of why Federal assistance is required to carry out the project, a description of the project's impact on continuous quality improvement, a description of how the community to be served will experience the increased access, and a plan for how the project will be sustained beyond Federal funding.

- It is important to note that funds received under this grant may not be used to build or acquire real estate/property, or for construction.
- In awarding grants, the Secretary of the HHS is to give preference to entities that are located in health professional shortage areas or medical underserved communities, or propose to develop projects with a focus on primary care and wellness.

Key Takeaways:

- 3 Types of Grants:
  - Expanding delivery of healthcare services in rural areas
  - Planning and implementation of integrated healthcare networks in rural areas
  - Planning and implementation of small healthcare provider quality improvement activities
- Grants awarded period changed from 'less than 3 years' to 'less than 5 years'
- Appropriations increased from $45 million to $79.5 million for each of fiscal years 2021 - 2025

SECTION 3214: UNITED STATES PUBLIC SERVICE MODERNIZATION

Section 3214 amended Section 203 of the Public Health Service Act (42 U.S.C. 204). This Act allows the Secretary of HHS to delegate any officer or employee of the following Federal departments under his powers:

- The Office of the Surgeon General
- The National Institutes of Health
- The Bureau of Medical Services
- The Bureau of State Services
- The Agency of Healthcare Policy and Research

The CARES act modifies the existing language of this Act that allows the Secretary of HHS to only have powers during a time of national emergency, and now also includes times of public health or national emergency, to cover the current COVID-19 pandemic.

Key Takeaways:

- Allows the Secretary of HHS to delegate to the aforementioned departments during times of public health or national emergency

SECTION 3215: LIMITATION ON LIABILITY FOR VOLUNTEER HEALTHCARE PROFESSIONALS DURING COVID-19 EMERGENCY RESPONSE

Professionals acting within the scope of their license, registration or certification, acting as a volunteer, that are providing healthcare services, in good faith, in response to a public health emergency, shall not be liable under Federal or State law for any harm caused by an act or omission of the professional, with respect to COVID-19. This section provides additional benefits to the Volunteer Protection Act of 1997, and shall sunset when the Secretary of HHS deems this public health emergency over.

Exceptions include harm caused by act or omission constituting any of the below:

- Willful or criminal misconduct
- Gross negligence
- Reckless misconduct
- Conscious flagrant indifference to rights and safety of individual

Key Takeaways:

- Limits the liability for healthcare professionals during this public emergency
- There are misconduct, negligence and flagrant indifference exceptions to this limitation on liability
- Sunsets when public health emergency is over

SECTION 3216: FLEXIBILITY FOR MEMBERS OF NATIONAL HEALTH SERVICE CORPS DURING EMERGENCY PERIOD

Under this section the Secretary of HHS has increased powers with respect to COVID-19 to assign members of the National Health Service Corps (NHSC) to respond to an emergency within a reasonable distance from the site which the members were originally assigned, and the total number of hours required are the same as were required prior to March 27, 2020.

Key Takeaways:

- Increased powers to assign members of NHSC to respond to an emergency:
    - Within reasonable distance
    - Total hours same as prior to March 27, 2020

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PART IV: HEALTHCARE WORKFORCE

Subtitle D – Finance Committee

SECTION 3701: EXEMPTION FOR TELEHEALTH SERVICES

Section 3701 amended Section 223(c) of the Internal Revenue Code of 1986. The exemption provided under Section 3701 allows for a temporary safe harbor for the absence of a deductible for telehealth services provided for individuals with a high deductible health plan (HDHP). "In the case of plan years beginning on or before December 31, 2021, a plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services." This allows HDHPs with a health savings account (HSA) to cover telehealth services prior to a patient reaching their deductible.

Key Takeaways:

- Allows for a temporary safe harbor for the absence of a deductible for telehealth services towards the HSA tax deduction
- Effective date is March 27, 2020

SECTION 3702: INCLUSION OF CERTAIN OVER-THE-COUNTER MEDICAL PRODUCTS AS QUALIFIED MEDICAL EXPENSES

Section 3702 amended Section 223(d)(2) of the Internal Revenue Code of 1986. Menstrual care products have been added to the list of qualified medical expenses (QMEs) that are eligible for reimbursement with an HSA, Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). Menstrual care products are defined as a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation. Reimbursement will apply to expenses incurred after December 31, 2019.

Key Takeaways:

- Menstrual care products added to list of QMEs eligible for reimbursement with:
    - HSAs
    - HRAs
    - FSAs
- Applies to expenses incurred after December 31, 2019

SECTION 3703: INCREASING MEDICARE TELEHEALTH FLEXIBILITIES DURING EMERGENCY PERIOD

Section 3703 amended Section 1135 of the Social Security Act (42 U.S.C. 1320b-5). The following includes provisions to expand HRSA authority to use Section 1135 waivers in a way that extends these to providers of telehealth services. During national emergencies, this has been amended to provide the Secretary of HHS authority to temporarily waive or modify healthcare related requirements, with respect to healthcare items and services furnished by a healthcare provider, in any emergency area, during any portion of an emergency period.

The change enables beneficiaries to access care through telehealth services, including in their home and from a broader range of providers. The Secretary of HHS has the authority to waive all laws governing payment for telehealth services to ensure providers are reimbursed. In addition, providers will be exempt from sanctions and penalties that arise from noncompliance during this time period.

Key Takeaways:

- During national emergency:
  - Enables beneficiaries to access care:
    - Through telehealth services
    - In their home
    - From a broader range of providers
  - Waives laws governing payment for telehealth services
  - Providers exempt from sanctions and penalties from noncompliance

SECTION 3704: ENHANCING MEDICARE TELEHEALTH SERVICES FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS DURING EMERGENCY PERIOD

Section 3704 amended Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)). The following includes provisions to expand HRSA authority to use Section 1135 waivers in a way that, during the emergency period, the Secretary of HHS shall pay for telehealth services furnished via telecommunications systems by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) to an eligible telehealth individual enrolled under this part, notwithstanding that the FQHC or RHC providing the telehealth service is not at the same location as the beneficiary.

Specifically, the provisions indicate:

- The term 'distant site' includes an FQHC or RHC that furnishes a telehealth service to an eligible telehealth individual.
- The term 'telehealth services' includes an FQHC or RHC service that is furnished using telehealth, to the extent that payment codes corresponding to services identified by the Secretary of HHS (professional consultations, office visits, and office psychiatry services, identified as of July 1, 2000 by HCPCS codes 99241–99275, 99201–99215, 90804–90809 and 90862, and as subsequently modified by the Secretary of HHS), and any additional service specified by the Secretary of HHS) are listed on the corresponding claim for such FQHC or RHC service.
- The Secretary of HHS shall develop and implement payment methods, which shall be based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule.
- Notwithstanding any other provision of law, the Secretary of HHS may implement such payment methods through program instruction or otherwise.
- Costs associated with telehealth services shall not be used to determine the amount of payment for the FQHC services prospective payment system or for the RHC services all-inclusive rate calculation.

Key Takeaways:

- Use of 1135 waivers to allow for payment of telehealth services:
  - Provided by FQHCs and RHCs
  - To an eligible individual (providing the telehealth service by provider is not at the same location as the beneficiary)
- Payment based on rates similar to national average payment rates for comparable services

SECTION 3705: TEMPORARY WAIVER OF REQUIREMENT FOR FACE-TO-FACE VISITS BETWEEN HOME DIALYSIS PATIENTS AND PHYSICIANS

Section 3705 amended Section 1881(b)(3)(B) of the Social Security Act (42 U.S.C. 1395rr(b)(3)(B)). This amendment allows individuals with end stage renal disease (ESRD) to receive monthly services via telehealth during the emergency period, removing the requirement to receive face to face clinical assessments during this period, as defined by the Secretary of HHS.

Key Takeaways:

- Individuals with ESRD allowed to receive monthly services via telehealth during the emergency period

SECTION 3706: USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD

Section 3706 amended Section 1814(a)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)). The following includes provisions to expand HRSA authority to use Section 1135 waivers in a way that, during the emergency period, as defined by the Secretary of HHS, a Hospice physician or nurse practitioner may conduct the required face-to-face encounters via telehealth in order to fulfill the hospice face-to-face recertification requirement.

Key Takeaways:

- During the emergency period, a hospice physician or nurse practitioner may conduct the required face-to-face encounters via telehealth in order to fulfill the hospice face-to-face recertification requirement

SECTION 3707: ENCOURAGING USE OF TELECOMMUNICATIONS SYSTEMS FOR HOME HEALTH SERVICES FURNISHED DURING EMERGENCY PERIOD

Section 3707 requires the Secretary of HHS to issue clarifying guidance encouraging the use of telecommunications systems, including remote patient monitoring, to furnish home health services consistent with the beneficiary care plan during the emergency period.

Key Takeaways:

- Encourages the use of telecommunications systems for home health services
- During emergency period

SECTION 3708: IMPROVING CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

Section 3708 amended Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)). Historically, only physicians have been permitted to order home health services for patients. This amendment increases the flexibility for physician assistants, nurse practitioners and other professionals, such as clinical nurse specialists or certified nurse midwives, to order and provide home health services. Typically, a physician must order and periodically review any home health services for a Medicare beneficiary, but changes under the CARES Act now allow a mid-level provider to make home health orders as the primary healthcare provider for the Medicare beneficiary in the home setting. With this increase in the number of providers authorized to make orders for home health services, Medicare beneficiaries should see reduced delays in obtaining necessary orders for home health services. As a result, home health agencies can now rely on written orders for home health services from a physician assistant, nurse practitioner or other mid-level provider as the provider in charge of a patient's care from start to finish. This change will remain in effect for six months after March 27, 2020.

Key Takeaways:

- Allows mid-level providers to make home health orders as the primary healthcare provider for the Medicare beneficiary in the home setting
- Will remain in effect for six months after March 27, 2020

SECTION 3709: ADJUSTMENT OF SEQUESTRATION

Section 3709 provides financial aid to hospitals and other healthcare providers that are subject to pay the two percent sequestration on all Medicare payments. The two percent reduction will be suspended from May 1, 2020 thru December 31, 2020. This means that Medicare plans and providers would receive an increase in payment rates of approximately two percent more than what they otherwise would have received during this time. The eight month period with Medicare payments no longer reduced by two percent equates to approximately $10.2 billion. In addition, Section 3709 amended Section 251A(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a(6)) by extending the mandatory sequestration through 2030 (one additional year).

Key Takeaways:

- Two percent sequestration will be suspended from May 1 through December 31, 2020
- Equates to approximately $10.2 billion
- Sequestration extended one year (until 2030)

SECTION 3710: MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM ADD-ON PAYMENT FOR COVID-19 PATIENTS DURING EMERGENCY PERIOD

Section 3710 amended Section 1886(d)(4)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(C))). For discharges that occur during the emergency period for which the diagnosis is COVID-19, Section 3710 increases the weighting factor that would otherwise apply to the DRG by 20%. It directs the Secretary of HHS to identify relevant discharges via "diagnosis codes, condition codes, or other such means as may be necessary." This adjustment is not considered in applying budget neutrality.

Key Takeaways:

- The weighting factor for DRGs with a diagnosis of COVID-19 will increase by 20 percent during the emergency period
- Adjustment not considered in applying budget neutrality

SECTION 3711: INCREASING ACCESS TO POST-ACUTE CARE DURING EMERGENCY PERIOD

Section 3711 provides a waiver of the three-hour rule that requires patients in inpatient rehabilitation facilities (IRF) to participate in three hours of rehabilitative therapy per day, or at least 15 hours of therapy within a seven consecutive day period, during the emergency period.

It also includes a waiver of the following site-neutral payment rate provisions for long-term care hospitals (LTCHs) with respect to inpatient hospital services furnished by a LTCH during the emergency period:

- LTCH 50-Percent Rule: Payment adjustment for LTCHs that do not have a discharge payment percentage for that period that is at least 50%; and
- Site-Neutral IPPS Payment Rate: Relating to the site neutral payment rate for a discharge if the admission occurs during such emergency period, and is in response to the public health emergency.

Key Takeaways:

- Waiver of the three-hour rule:
  - Three hours of rehabilitation therapy per day; or
  - At least 15 hours of therapy within seven consecutive days
- Waiver of the site-neutral payment rate provisions for LTCHs:
  - LTCH 50 Percent Rule
  - Site-Neutral IPPS Payment Rate
- The above remain in effect during the emergency period

SECTION 3712: REVISING PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT UNDER THE MEDICARE PROGRAM THROUGH DURATION OF EMERGENCY PERIOD

In rural and noncontiguous areas, Section 3712 prevents scheduled durable medical equipment (DME) payment adjustments from going into effect until December 31, 2020, or until after the emergency period ends. DME furnished in rural and noncontiguous areas will be paid a 50/50 blended rate that includes one-half based on the current fee-schedule and one-half based on the pre-adjusted rates through the later of December 31, 2020 or for the duration of the emergency period.

For areas other than rural and noncontiguous, the fee schedule amount for the area becomes 75 percent of the adjusted payment amount and 25 percent of the unadjusted fee schedule amount, for the period of March 6, 2020 through the end of the emergency period.

Key Takeaways:

- Rural and Noncontiguous Areas:
  - Paid at 50 percent based on current fee schedule and 50 percent based on pre-adjusted rates
  - Scheduled DME payment adjustments will go into effect the later of December 31, 2020 or the end of the emergency period
- Other Than Rural and Noncontiguous Areas:
  - Fee schedule amount calculated at 75 percent of the adjusted payment amount and 25 percent of the unadjusted fee schedule amount
  - Scheduled for the period of March 6, 2020 through the end of the emergency period

SECTION 3713: COVERAGE OF THE COVID-19 VACCINE UNDER PART B OF THE MEDICARE PROGRAM WITHOUT ANY COST-SHARING

Section 3713 amended Section 1861(s)(10)(A) of the Social Security Act (42 U.S.C. 1395x(s)(10)(A)). This section expands the term “medical and other health services” to include “vaccine administration”, and, with respect to COVID-19 vaccine and its administration, the deductible shall not apply. This is consistent with how Medicare treats the seasonal flu vaccine. Congress anticipates that waiving co-pays will increase the number of vaccines obtained by beneficiaries, as these vaccines become available. The effective date for this change is March 27, 2020.

Key Takeaways:

- Deductible does not apply to COVID-19 vaccine and its administration
- Effective date is March 27, 2020

SECTION 3714: REQUIRING MEDICARE PRESCRIPTION DRUG PLAN AND MA-PD PLANS TO ALLOW DURING THE COVID-19 EMERGENCY PERIOD FOR FILLS AND REFILLS OF COVERED PART D DRUGS FOR UP TO A 3-MONTH SUPPLY

Section 3714 amended Section 1860D-4(b) of the Social Security Act (42 U.S.C. 1395w-104(b)). This provision requires Medicare Part D plan sponsors (including MA-PD sponsors) to allow enrollees to obtain a single fill or refill, without utilization management, of an up to 90 day supply of any covered Part D drug on a one-time basis. This change is meant to allow beneficiaries to stock up on needed medications without experiencing refill too soon edits. This is effective January 27, 2020 through the end of the emergency period.

Key Takeaways:

- Enrollees able to obtain a single fill or refill, without utilization management, of an up to 90 day supply of any covered Part D drug on a one-time basis
- Effective January 27, 2020 through the end of the emergency period

SECTION 3715: PROVIDING HOME AND COMMUNITY-BASED SERVICES IN ACUTE CARE HOSPITALS

Section 3715 amended Section 1902(h) of the Social Security Act (42 U.S.C. 1396a(h)). Section 1902(h) of the Social Security Act states that the Secretary of HHS is not authorized to limit the amount of payment that may be made under a plan for home and community care.

Section 3715 expands Section 1902(h) by not prohibiting receipt of home and community care services within an acute care setting that are:

- Identified as an individual's person-centered plan of services (or comparable plan of care)
- Provided to meet needs of the individual that are not met through the provision of hospital services
- Not a substitute for services that a hospital is obligated to provide through its conditions of participating or under Federal or State Law
- Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functions

Key Takeaways:

- Expanded allowance of home and community care services within an acute care setting:
    - Identified as an individual's person-centered plan of services
    - Provided to meet needs of the individual that are not met by hospital services
    - Not a substitute for hospital-obligated services under Federal or State Law
    - Designed to ensure smooth transitions, and to preserve the individual's functions

SECTION 3716: CLARIFICATION REGARDING UNINSURED INDIVIDUALS

Section 3716 amended Section 1902 of the Social Security Act (42 U.S.C. 1396a), as added by section 6004(a)(3)(C) of the Families First Coronavirus Response Act. The description of expanded access for state medical assistance plans to no longer exclude the clause "where the assistance would only be available to people under 65 years of age, not pregnant, or enrolled in other benefits". Additionally, this describes how individuals impacted by tuberculosis, breast or cervical cancer, and patients meeting income standards are eligible for certain medical assistance under the Social Security Act.

Key Takeaways:

- Corrects an error that excluded low-income adults in states that have not yet adopted the Affordable Care Act (ACA) Medicaid expansion from such coverage.
- Amends the definition of "uninsured individual" to clarify that individuals with certain categories of Medicaid that do not provide "minimum essential coverage" also may be considered as uninsured for purposes of eligibility for the new optional COVID-19 testing group.

SECTION 3717: CLARIFICATION REGARDING COVERAGE OF COVID-19 TESTING PRODUCTS

Section 3717 amended Section 1905(a)(3) of the Social Security Act (42 U.S.C. 1396d(a)(3)), as added by section 6004(a)(1)(C) of the Families First Coronavirus Response Act. This section amended the Medicaid statute to provide that COVID-19 diagnostic products administered during the emergency period (including in-vitro diagnostics) are covered Medicaid services (and must be provided with no cost sharing). Section 3717 amends the language to provide that such diagnostic products are covered services even if they have not been approved, cleared or authorized under specified sections of the Federal Food, Drug and Cosmetic Act (FDCA).

Key Takeaways:

- COVID-19 diagnostic products administered during the emergency period (including in-vitro diagnostics) are covered Medicaid services (and must be provided with no cost sharing)
- These diagnostic products are covered services even if they have not been approved, cleared or authorized under specified sections of the FDCA

SECTION 3718: AMENDMENTS RELATING TO REPORTING REQUIREMENTS WITH RESPECT TO CLINICAL DIAGNOSTIC LABORATORY TESTS

Section 3718 amended Section 1834A(a)(1)(B) of the Social Security Act (42 U.S.C. 1395m-1(a)(1)(B)). This section prevents scheduled reductions in Medicare payments for clinical diagnostic laboratory tests furnished to beneficiaries in 2021. It also delays by one year the upcoming reporting period during which laboratories are required to report private payer data.

Key Takeaways:

- Prevents scheduled reductions in Medicare payments for clinical diagnostic laboratory tests furnished to beneficiaries in 2021
- Delays by one year the upcoming reporting period during which laboratories are required to report private payer data

SECTION 3719: EXPANSION OF THE MEDICARE HOSPITAL ACCELERATED PAYMENT PROGRAM DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

Section 3719 amended Section 1815 of the Social Security Act (42 U.S.C. 1395g). In order to increase cash flow to providers and suppliers impacted by the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) is expanding the Accelerated and Advance Payments program.

Accelerated/Advance Payments:

An accelerated/advance payment is intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. However, these expedited payments can also be offered in circumstances such as national emergencies.

CMS has been authorized to provide accelerated or advance payments during the COVID-19 crisis to any Medicare provider or supplier who submits a request to their Medicare Administrative Contractor (MAC) and meets the required qualifications.

Eligibility:

To qualify for accelerated/advance payments, the provider/supplier must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form
- Not be in bankruptcy
- Not be under active medical review or program integrity investigation
- Not have any outstanding delinquent Medicare overpayments

Amount of Payment:

Qualified providers and suppliers are to use the Accelerated or Advance Payment Request form provided on each MAC's website. Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period.

- Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are able to request up to 100% of the Medicare payment amount for a six-month period
- Critical access hospitals can request up to 125% of their payment amount for a six-month period
- Medicare Part B providers can request up to 100% of their payment amount for a three-month period

Processing Time:

Each MAC will work to review and issue payments within seven calendar days of receiving the request.

Repayment:

CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of payment issuance. The repayment timeline is broken out by provider type as follows:

- Inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals have up to one year from the date the accelerated payment was made to repay the balance
- All other Part A provider and Part B suppliers will have 210 days from the date the accelerated or advance payment was made to repay the balance

Recoupment and Reconciliation:

- Providers and suppliers will receive full payments for their claims during the 120-day delay period. At the end of the 120-day period, the recoupment process will begin, and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advance payment. Therefore, instead of receiving payment for newly submitted claims, the provider's/supplier's outstanding accelerated/advance payment balance is reduced by the claim payment amount.
- The majority of hospitals, including inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals, will have up to one year from the date the accelerated payment was made to repay the balance. At one year from the accelerated payment receipt, the MACs will perform a manual check to determine if there is a balance remaining, and, if so, send a request for repayment of the remaining balance. All other Part A

providers not listed above, and Part B suppliers, will have up to 210 days for the reconciliation process to begin.

- For the small subset of Part A providers who receive Period Interim Payments (PIP), the accelerated payment reconciliation process will happen at the final cost report process (180 days after the fiscal year closes).

Key Takeaways:

- Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals
  - Payment amount: Up to 100% of the Medicare payment amount for a six-month period
  - Repayment: Up to one year from the date the accelerated payment was made (beginning 120 days after the date of payment issuance)
- Critical access hospitals
  - Payment amount: Up to 125% of the Medicare payment amount for a six-month period
  - Repayment: Up to one year from the date the accelerated payment was made (beginning 120 days after the date of payment issuance)
- All other Part A provider and Part B suppliers
  - Medicare Part B providers can request up to 100% of their payment amount for a three-month period
  - Repayment: Up to 210 days from the date the accelerated payment was made (beginning 120 days after the date of payment issuance
- MACs will work to review and issue payments within seven calendar days of receiving the request

More information, and a step by step application guide, the CMS Fact sheet can be found on the CMS website.

SECTION 3720: DELAYING REQUIREMENTS FOR ENHANCED FMAP TO ENABLE STATE LEGISLATION NECESSARY FOR COMPLIANCE

Section 3720 amended Section 6008 of the Families First Coronavirus Response Act. Section 6008 established a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) Medicaid matching rate, available retroactive to January 1, 2020, through the end of the quarter during which the emergency period ends. CMS indicates that all states and territories are eligible for the increased FMAP, provided they meet the requirements of section 6008(b) and (c) of the Families First Coronavirus Response Act. These are:

- States must maintain eligibility standards, methodologies, or procedures equal or less restrictive than those in effect on January 1, 2020
- States cannot raise any Medicaid premiums above those in effect on January 1, 2020
- States must commit to not dis-enroll any beneficiary enrolled as of the date of enactment of this section or who enrolls for benefits during the emergency period, regardless of change in eligibility status (known as "continuous coverage")
- States must provide full coverage for any testing services and treatments for COVID–19, including vaccines, specialized equipment and therapies

Key Takeaways:

- 6.2 percentage point increase in the FMAP Medicaid matching rate
- Available retroactive to January 1, 2020
- Through the end of the quarter during which the emergency period ends

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SUBTITLE E: HEALTH AND HUMAN SERVICES EXTENDERS

Part I – Medicare Provisions

SECTION 3801: EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR UNDER THE MEDICARE PROGRAM

Section 3801 amended Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)). The physician fee schedule has several components that comprise each fee, such as the work component (resources used in providing the service), practice expense component (general overhead expenses) and malpractice component (malpractice expenses). Each of these components is accumulated and grouped into regional fee schedule areas, and then compared to the national average for each section (similar to the hospital wage index final calculation). The result is a work geographic index. These factors are reviewed and adjusted no less than every three years.

As a result of this section, if a work geographic index was less than 1.000 for a particular area, then the Secretary of HHS increased the index to 1.000. This resulted in an increase in payments for the work component of the Physician Fee Schedule in areas where labor costs were lower than the national average.

This section extended the work geographic index floor provision of the physician fee schedule through December 1, 2020.

Key Takeaways:

- Work geographic index in areas that were less than 1.000 were increased to 1.000
- This provision was extended through December 1, 2020

SECTION 3802: EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT AND SELECTION

Section 3802 amended Section 1890(d)(2) of the Social Security Act (42 U.S.C. 1395aaa(d)(2)). This section added $20,000,000 to the funding for quality measure endorsement, input and selection for the period beginning on October 1, 2020 and ending on November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for Fiscal Year 2020.

Key Takeaways:

- $20.0 million was added to the funding for quality measure endorsement, input and selection
- This will cover the period of October 1, 2020 through November 30, 2020

SECTION 3803: EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS

Section 3803 extends funding until December 1, 2020, for grants to states to provide information, counseling and assistance to individuals eligible for Medicare low-income programs. It also extends additional funding for aging and disability resource centers through December 1, 2020. Section 3803 provides:

- Additional funding for state health insurance programs of $13,000,000 for the period October 1 through November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020

- Additional funding for area agencies on aging of $7,500,000 for the period October 1 through November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020
- Additional funding for aging and disability resource centers of $5,000,000 for the period of October 1 through November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020
- Additional funding for the contract with the National Center for Benefits Outreach and Enrollment (NCBOE) of $12,000,000 for the period of October 1 through November 30, 2020, the amount equal to the pro rata portion of the amount appropriated for such period for fiscal year 2020

Key Takeaways:

- Additional funding provided:
  - State health insurance programs of $13,000,000
  - Area agencies on aging of $7,500,000
  - Aging and disability resource centers of $5,000,000
  - NCBOE of $12,000,000
- Funding extended for all sections from October 1 through November 30, 2020

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Part II: Medicaid Provisions

SECTION 3811: EXTENSION OF THE MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION PROGRAM

Section 3811 amended Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note). The Deficit Reduction Act of 2005 gave individual states the flexibility to modify their Medicaid Programs. The Money Follows the Person Rebalancing Demonstration Program provides funding to state Medicaid Programs to enhance and increase the use of home and community-based services (HCBS). This section extended the program through November 30, 2020. Appropriations available from January 1 through September 30, 2020 are $337,500,000, and for the period of October 1 through November 30, 2020, the amount will be based on a pro rata allocation.

Key Takeaways:

- Money Follows the Person program extended through November 30, 2020
- Appropriations:
  - January 1 through September 30, 2020: $337.5 million
  - October 1 through November 30, 2020: Based on a pro rata allocation

SECTION 3812: EXTENSION OF SPOUSAL IMPOVERISHMENT PROTECTIONS

Section 3812 amended Section 2404 of Public Law 111-148 (42 U.S.C. 1396r-5 note). This section extends the Medicaid spousal impoverishment protection programs through November 30, 2020. These programs allow for a spouse that qualifies for nursing home care to live at home and utilize home and community-based services.

Key Takeaways:

- Spousal impoverishment protection programs extended through November 30, 2020
- Allow states to disregard individuals' spousal income and assets when determining eligibility for Medicaid home and community-based services and support

SECTION 3813: DELAY OF DSH REDUCTIONS

Section 3813 amended Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r-4(f)(7)(A)), which established Medicaid disproportional share hospital (DSH) allotment reductions for the period beginning May 23, 2020 and ending September 30, 2020 and for fiscal years 2021 through 2025.

This section delays these scheduled Medicaid DSH payment reductions until December 1, 2020.

Key Takeaways:

- The scheduled Medicaid DSH payment reductions are delayed until December 1, 2020

SECTION 3814: EXTENSION AND EXPANSION OF COMMUNITY MENTAL HEALTH SERVICES DEMONSTRATION PROGRAM

Section 3814 amended Section 223(d) of the Protecting Access to Medicare Act of 2014 (42 U.S.C. 1396a-note). The Medicaid Community Mental Health Services Demonstration program provides coordinated care to patients with mental health and substance use disorders. This section extends the date of participation through November 30, 2020, as well as allowing two more states to participate.

Key Takeaways:

- The date of participation in the Medicaid Community Mental Health Services Demonstration program has been extended through November 30, 2020

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If you would like to discuss these matters further, please contact a member of our healthcare advisory group via email or at 800.244.7444.

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GLOSSARY OF TERMS

CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
ESRD	End Stage Renal Disease
FDCA	Federal Food, Drug and Cosmetic Act
FMAP	Federal Medical Assistance Percentage
FSA	Flexible Spending Account
HCBS	Home and Community Based Services
HDHP	High Deductible Health Plan
HHS	U.S. Department of Health and Human Services
HRA	Health Reimbursement Arrangement
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
IRF	Inpatient Rehabilitation Facilities
LTCH	Long Term Care Hospitals
MAC	Medicare Administrative Contractor
NHSC	National Health Service Corps
NCBOE	National Center for Benefits Outreach and Enrollment
PIP	Periodic Interim Payments

BNN HEALTHCARE ADVISORY GROUP CONTACTS

ERIC WETHERELL, CPA, MSPA

Principal & Healthcare Advisory Group Leader
ewetherell@bnncpa.com

PAUL LETALIEN, CPA

Principal
pletalien@bnncpa.com

DENIS HOULE

Senior Manager
dhoule@bnncpa.com

ROBERT GILBERT, FHFMA, COC

Senior Manager
rgilbert@bnncpa.com

DIANNE RODRIGUE, PA, MHP, CCDS, CRC, CPC

Senior Manager
drodrigue@bnncpa.com

GINA HOBERT, MBA, CHC, CPC-I, CEMC, CRC, CPMA

Senior Manager
ghobert@bnncpa.com

PAMELA COOK

Senior Manager
pcook@bnncpa.com

MARC LEVY

Senior Manager
mlevy@bnncpa.com

GREG KNIGHT

Manager
gknight@bnncpa.com

STEPHANIE RICHIO

Manager
srichio@bnncpa.com

EVAN DRESSEL, MBA, CHFP

Manager
edressel@bnncpa.com

PAIGE RICCI, MHA

Senior Advisor
pricci@bnncpa.com

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BNN COVID-19 RESOURCE CENTER

The dynamic shifts in events globally, nationally, and in our hometowns have transformed our world in ways we could not have imagined. Our task force is here to keep you informed of technical updates for individuals and businesses alike so you can understand the changes and mitigate risk.

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