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THE RESULTS WILL AMAZE YOU.

Understanding Cost Sharing & Balance Billing COVID-19 Public Health Emergency (PHE)

R1 Regulatory

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Today’s R1 Regulatory Team

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Amber has been leading the regulatory advisory and guidance function at R1 RCM since 2015. Prior to joining R1, Amber was the compliance officer for the largest public hospital in the United States, Jackson Memorial Hospital & Holtz Children’s Hospital in Miami, Florida. Amber began her career as a regulator at the Centers for Medicare & Medicaid Services, Division of Technical Payment Policy and then served in the Office of General Counsel for CMS’s Program Integrity Division. Amber also practiced law at a mid-size regional law firm where she focused on legal and regulatory issues in health care transactions between physician groups and hospitals.

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Andrew has 7+ years of healthcare regulatory & compliance experience. As the Director, Regulatory & Billing Compliance for R1, he primarily focuses on government payer reimbursement issues, claims processing and payment, and fraud & abuse laws and investigations. Prior to joining R1, Andrew worked as an attorney in the Office of the Secretary for the Department of Health and Human Services (HHS) in Washington, D.C., where he worked primarily on Medicare policy. Prior to his time in the Secretary’s office, Andrew also worked as a regulatory counsel for the Food and Drug Administration (FDA) and as a compliance attorney for a regional health insurance company.

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The purpose of this presentation is to briefly cover regulatory updates related to provider relief payments and patient cost-sharing updates for COVID-19 testing and testing-related services. As providers continue implementing their COVID-19 response plans, all decisions should be implemented with the assistance of your legal and compliance resources.

This presentation is not intended to supersede or replace any information you have received related to your specific facts and circumstances.

To the best of our knowledge, this information was correct at the time of publication. Given the fluid situation, and with updated guidance issued regularly, please be aware that some or all of this information may no longer apply.

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Important Terms

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- **Cost Sharing**: any copayment, coinsurance, deductible, or other similar charge.
- **Balance Billing**: collecting amounts that represent the difference between a provider's charges and amounts paid by a third-party payer.
- **Cost-sharing Waiver**: determination by a provider or payer to not collect or impose an allowable copayment, coinsurance amount, deductible, or other similar charge.

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Balance Billing

CARES Act Provider Relief Fund

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- $30B is being distributed to providers
- Providers must sign and agree to the terms and conditions of payment within 30 days.
- Providers must agree not to seek collection of "out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider."

CARES Act Provider Relief Fund

President Trump is providing support to healthcare providers fighting the COVID-19 pandemic. On March 27, 2020, the President signed the bipartisan CARES Act that provides $100 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response. This funding will be used to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19.

Immediate infusion of $30 billion into healthcare system

Recognizing the importance of delivering funds in a fast and transparent manner, $30 billion is being distributed immediately – with payments arriving via direct deposit beginning April 10, 2020 – to eligible providers throughout the American healthcare system. **These are payments, not loans, to healthcare providers, and will not need to be repaid.**

Who is eligible for initial $30 billion

- All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution.
- Payments to practices that are part of larger medical groups will be sent to the group's central billing office.
  - All relief payments are made to the billing organization according to its Taxpayer Identification Number (TIN).
- As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

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Provider Relief Unanswered Questions

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- What is a "COVID-19 patient" for purposes of this requirement?
  - Will this include patients who present with symptoms but test negative?
  - Will this include presumptive diagnoses of COVID-19?
- How will providers know what the patient would have otherwise been required to pay if the care had been provided by an in-network provider?
- What if the patient is uninsured? The U.S. Department of Health & Human Services Secretary stated in the White House press briefing:
  - "Providers' costs of delivering COVID-19 care for the uninsured, sending the money to providers through the same mechanism used for testing."
    - Note: still waiting for additional guidance as to the mechanism for these funds.
  - "As a condition of receiving funds under this program, providers will be forbidden from *balance billing the uninsured* for the cost of their care. Providers will be reimbursed at Medicare rates."
    - Note: "balance billing" is not a term typically used when billing self-pay patients without coverage and we are waiting for additional guidance.

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Cost Sharing

Cost Sharing for COVID-19 Testing-Related Services

- The Families First Coronavirus Response Act (FFCRA):
  - Waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services.
  - Requires health insurance issuers and employer group health plans to cover COVID-19 testing without cost sharing.
  - Requires health insurance issuers and employer group health plans to cover items and services related to diagnostic testing for the detection or the diagnosis of COVID-19 without cost sharing.
- Coronavirus Aid, Relief, and Economic Security (CARES) Act
  - Expanded coverage and cost-sharing protections to additional diagnostic services
  - Plans and issuers must reimburse any provider of COVID-19 diagnostic testing in an amount that equals:
    - The negotiated rate, if applicable; OR
    - The cash price for such service that is listed by the provider on a public website.

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FFCRA: COVID-19 Testing-Related Services (Medicare)

The following criteria **must be satisfied** before applying the "CS" modifier (on or after March 18, 2020) to an E&M service code reported on a Medicare outpatient claim:

(1) An E&M service is reported within the code ranges for the following services:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services;

(2) The E&M service is provided during the COVID-19 (PHE);

(3) The E&M service results in an order for a clinical diagnostic laboratory test described by HCPCS U0001, U0002, U0003, U0004 or 87635; **AND**

(4) The E&M service relates to

a. The furnishing or administration of such test or
b. To the evaluation of such individual for purposes of determining the need of such individual for such test.

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FFCRA: COVID-19 Testing-Related Services (Health Plans & Issuers)

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- Plans and issuers must cover:
    1. Items and services furnished to an individual
    2. During visits (in-person and telehealth) that result in an order for, or administration of, a COVID-19 diagnostic test if:
        a. The items or services relate to the furnishing or administration of the test or
        b. To the evaluation of such individual for purposes of determining the need of the individual for the test, as determined by the individual's attending healthcare provider.
- If the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit to determine the need for COVID-19 diagnostic testing; and
- The visit results in an order for, or administration of, COVID-19 diagnostic **testing**, the plan or issuer must provide coverage for **the related tests** under section 6001(a) of the FFCRA.
- This coverage must be provided without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider (in accordance with accepted standards of current medical practice).

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What are “Visits”?

- The Departments construe the term “visit” to include both traditional and non-traditional care settings in which a COVID-19 diagnostic test is ordered or administered, such as:
  - Office visits
  - In-person and telehealth
  - Urgent care centers
  - Emergency rooms
  - COVID-19 drive-up screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing

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What about non-contracted payers?

- Section 3202(a) of the CARES Act provides that a plan or issuer providing coverage of items and services described in section 6001(a) of the FFCRA shall reimburse the provider of the diagnostic testing as follows:
  - Do you have a negotiated rate before the PHE?
    - **Yes**: the negotiated rate shall apply throughout the PHE
    - **No**: Reimburse the provider in an amount that equals:
      - The cash price for such service as listed by the provider on a public internet website; or
      - The plan or issuer may negotiate a rate with the provider for less than such cash price.

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Challenges Related to Cost-Sharing

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- For Medicare, it is hard to identify situations where COVID-19 test was ordered but never provided, limiting automation of the “CS” modifier
- For other health plans and issuers, are they paying the full allowable rate when testing is ordered and provided?
- How are payers identifying these claims in their processing systems?

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Questions?