Coronavirus Aid, Relief and Economic Security ("CARES") Act | Healthcare Regulatory Overview

Regulatory Compliance

March 30, 2020

Executive Summary | R1 Regulatory Analysis

Overview

- The analysis included within this deck is focused on specific sections within Title III of the CARES Act that are relevant to healthcare revenue cycle management (RCM) services

Key Recommended Actions

- Acute care customers to publish cash price of COVID-19 diagnostic tests on customer website || Sec. 3202
- Hospitals and other providers may request from their Medicare Administrative Contractor (MAC) upfront payments and then have reconciliation and recoupment of claims later to offset amounts due || Sec. 3719
- Educate risk management on professional liability for certain volunteers || Sec. 3215

Division A—Keeping Workers Paid and Employed, Health Care System Enhancements, and Economic Stabilization

- Title I—Keeping American Workers Paid and Employed Act
- Title II—Assistance for American Workers, Families and Businesses
  - Subtitle A—Unemployment Insurance Provisions
  - Subtitle B—Rebates and Other Individual Provisions
  - Subtitle C—Business Provisions
- **Title III—Supporting America's Health Care System in the Fight Against the Coronavirus**
  - **Subtitle A—Health Provisions**
    - Part I Addressing Supply Shortages
      - Subpart A—Medical Product Supplies
      - Subpart B—Mitigating Emergency Drug Shortages
      - Subpart C—Preventing Medical Device Shortages
    - Part II Access to Health Care for COVID-19 Patients
      - Subpart A—Coverage of Testing and Preventive Services
      - Subpart B—Support for Health Care Providers
      - Subpart C—Miscellaneous Provisions
    - Part III Innovation
    - Part IV Health Care Workforce
  - Subtitle B—Education Provisions
  - Subtitle C—Labor Provisions
  - Subtitle D—Finance Committee
  - Subtitle E—Health and Human Services Extenders
- Title IV—Economic Stabilization and Assistance to Severely Distressed Sectors of the U.S. Economy
- Title V—Coronavirus Relief Funds

SEC. 3202 Pricing of Diagnostic Testing.

Topic	Guidance
Reimbursement	A group health plan or a health insurance issuer providing coverage of items and services shall reimburse the provider of the diagnostic testing as follows: • If the health plan or issuer had a negotiated rate with such provider in effect before the public health emergency, such negotiated rate shall apply • If the health plan or issuer did not have a negotiated rate with such provider in effect before the public health emergency, then it shall 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 such plan or issuer may negotiate a rate with such provider for less than such cash price.
Requirement to Publish Cash Price for COVID-19 Diagnostic Testing	• During the emergency period, each provider of a diagnostic test for COVID-19 shall make public the cash price for such test on a public internet website of such provider. • Civil Monetary Penalties. Any provider of a diagnostic test for COVID-19 that is not in compliance and has not completed a corrective action plan to comply with the requirements in an amount not to exceed $300 per day that violation is ongoing.

SEC. 3203. Rapid Coverage of Preventive Services and Vaccines for Coronavirus.

Topic	Guidance

Rapid Coverage of Preventive Services and Vaccines for Coronavirus	• Requires that group health plans and health insurance issuers cover (without cost-sharing) any qualifying coronavirus preventive service.
	• Qualifying Coronavirus Preventive Service*:*
	  • An item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—
	  • An evidence-based item or service that has in effect a rating of ‘‘A’’ or ‘‘B’’ in the current recommendations of the United States Preventive Services Task Force; or
	  • An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

SEC. 3211. Supplemental Awards for Health Centers.

Topic	Guidance
Supplemental Awards for Health Centers	• Provides $1.32B for fiscal year 2020 for supplemental awards for the detection of SARS-CoV-2 or the prevention, diagnosis, and treatment of COVID-19. • “Health centers,” as defined 42 U.S.C. 254b(r), are eligible to receive additional funding related to COVID-19

SEC. 3212. Telehealth Network and Telehealth Resource Centers Grant Programs.

Topic	Guidance
Reauthorization of Telehealth Grant	• Reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services.

Current HRSA Telehealth Funding Opportunity	• Promoting rural Tele-emergency services with an emphasis on tele-stroke, tele-behavioral health, and Tele-Emergency Medical Services (Tele-EMS).
	• This will be achieved by enhancing telehealth networks to deliver 24-hour Emergency Department (ED) consultation services via telehealth to rural providers without emergency care specialists.
	• Tele-emergency is defined as "an electronic, two-way, audio/visual communication service between a central emergency healthcare center (Tele-emergency hub) and a distant hospital emergency department (ED) (remote ED) designed to provide real-time emergency care consultation.
	• These services may include assessment of patients upon admission to the ED, interpretation of patient symptoms and clinical tests or data, supervision of providers administering treatment or pharmaceuticals, or coordination of patient transfer from the local ED.
	• Eligible applicants include rural or urban nonprofit entities that will provide direct clinical services through a telehealth network.
	  • Each entity participating in the networks may be a nonprofit or for-profit entity.
	  • Faith-based, community-based organizations and tribal organizations are eligible to apply.
	  • Services must be provided to rural areas, although the applicant can be located in an urban area.

SEC. 3215. Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response.

Topic	Guidance
Limitation for Volunteer Workers	• A health care professional shall not be liable under Federal or State law for any harm caused by an act or omission of the professional in the provision of health care services during the public health emergency with respect to COVID-19 if– • the professional is providing health care services in response to such public health emergency, as a volunteer; and • the act or omission occurs— (A) in the course of providing health care services; (B) in the health care professional's capacity as a volunteer; (C) in the course of providing health care services that— (i) are within the scope of the license, registration, or certification of the volunteer, as defined by the State of licensure, registration, or certification; and (ii) do not exceed the scope of license, registration, or certification of a substantially similar health professional in the State in which such act or omission occurs; and (D) in a good faith belief that the individual being treated is in need of health care services.

SEC. 3215. Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response.

Topic	Guidance
Exceptions	• If the harm was caused by an act or omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed by the health care professional; or • the health care professional rendered the health care services under the influence (as determined pursuant to applicable State law) of alcohol or an intoxicating drug.
Effective Date	• Date of enactment • Sunset is at the end of the public health emergency
State Law	• Law expressly preempts State law

SEC. 3215. Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response.

Topic	Guidance
Definition of Harm	Physical, non-physical, economic, and noneconomic losses
Definition of Health care professional	An individual who is licensed, registered, or certified under Federal or State law to provide health care services
Definition of Health care services	Services provided by a health care professional, or by any individual working under the supervision of a health care professional that relate to— (A) the diagnosis, prevention, or treatment 19 of COVID-19; or (B) the assessment or care of the health of a human being related to an actual or suspected case of COVID-19

SEC. 3215. Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response.

Topic	Guidance

Definition of Volunteer	• A health care professional who, with respect to the health care services rendered, does not receive compensation or any other thing of value in lieu of compensation, which compensation—
	  • Includes a payment under any insurance policy or health plan, or under any Federal or State health benefits program; and
	  • Excludes—
	  • Receipt of items to be used exclusively for rendering health care services in the health care professional's capacity as a volunteer; and
	  • Any reimbursement for travel to the site where the volunteer services are rendered and any payments in cash or kind to cover room and board, if services are being rendered more than 75 miles from the volunteer's principal place of residence

SEC. 3221. Confidentiality and Disclosure of Records Relating to Substance Use Disorder.

Topic	Guidance
Substance-Use Disorder Treatment Records	Promotes additional care coordination by aligning the 42 CFR Part 2 (Part 2) regulations, which govern the confidentiality and sharing of substance use disorder treatment records, with the Health Insurance Portability and Accountability Act (HIPAA).
Confidentiality and Disclosure of Substance-Use Disorder Records	Permits certain re-disclosures of substance use disorder treatment records to covered entities, business associates, and other programs subject to HIPAA after obtaining a patient's initial written consent.

SEC. 3224. Guidance on Protected Health Information.

Topic	Guidance
Guidance on COVID-19 and PHI	Directs the Secretary of HHS to issue guidance with respect to the sharing of patients' protected health information (PHI) during the COVID-19 public health emergency no later than 180 days after the enactment of the CARES Act.
Required Information	Such guidance must include information on compliance with HIPAA regulations and applicable policies.
Related Guidance	HHS has recently released guidance (unrelated to this directive in the CARES Act) detailing the circumstances under which covered entities may disclose PHI about an individual who has been infected with or exposed to COVID-19 to law enforcement, paramedics, first responders, and public health authorities without the individual's authorization in compliance with HIPAA regulations.

SEC. 3701. Exemption for Telehealth Services

Topic	Guidance
High-deductible Health Plan Exemption	Creates an exemption in the Internal Revenue Code for high deductible health plans related to the use of telehealth and other remote care services.
Details of Exemption for High-deductible Health Plans that Waive Patient Cost-Sharing for Telehealth Services	For plan years beginning on or before December 31, 2021, high-deductible health plans, which normally are required to have their enrollees meet certain cost-sharing requirements, will not fail to remain eligible to be treated as a high-deductible health plan if they do not require a deductible for telehealth and other remote care services.

SEC. 3703. Increasing Medicare Telehealth Flexibilities During Emergency Period.

Topic	Guidance
Coronavirus Preparedness and Response Supplemental Appropriations Act	Amends changes made to Social Security Act sec. 1135 by the Coronavirus Preparedness and Response Supplemental Appropriations Act, passed by Congress on March 6, 2020.
Telehealth Coverage and Requirements	• Section 1135 contains language allowing the Secretary of HHS to waive certain Medicare requirements when emergency declarations are made by the Secretary of HHS and the President. The March 6th law, passed before the President declared a National Emergency, allowed Medicare to increase telehealth coverage during the COVID-19 Public Health Emergency declared by the Secretary on January 31, 2020. • 1135(b)(8) is now updated to clarify the requirements for telehealth services by referencing the requirements found in section 1834(m) of the Social Security Act, and removes more complicated cross-references found in the March 6th language.

SEC. 3704. Enhancing Medicare Telehealth Services for Federally Qualified Health Centers (FQHC) and Rural Health Clinics during Emergency Period.

Topic	Guidance
Medicare Telehealth Services for Federally Qualified Health Centers (FQHC) and Rural Health Clinics	• Medicare will pay for telehealth services that are furnished via a telecommunications system by a FQHC or a rural health clinic to an eligible telehealth Medicare beneficiary provided that the telehealth service is not at the same location as the patient • Distant Site: A Federally qualified health center or rural health clinic that furnishes a telehealth service to an eligible telehealth individual; and • Telehealth Services: includes a rural health clinic service or FQHC service that is furnished using telehealth to the extent that payment codes corresponding to services identified by the Secretary are listed on the corresponding claim for such rural health clinic service or FQHC service.
Payments	• Shall be based on payment rates that are like the national average payment rates for comparable telehealth services under the physician fee schedule. • Costs associated with telehealth services shall not be used to determine the amount of payment for FQHCs services under the prospective payment system or for rural health clinic services under the methodology for all-inclusive rates.

Various Telehealth Provisions (Sec. 3705; 3706; 3707)

Topic	Guidance

Telehealth Requirements: Face-to-Face Encounters	• SEC 3705. Temporary Waiver of Requirement for Face-to-Face Visits Between Home Dialysis Patients and Physicians.
	  • Eliminates requirement that nephrologists conduct face-to-face periodic evaluations of patients on home dialysis.
	• SEC. 3706. Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care During Emergency Period.
	  • A hospice physician or nurse practitioner may conduct a face-to-face encounter required under this clause via telehealth.

Telecommunications	• SEC. 3707. Encouraging use of Telecommunications Systems for Home Health Services Furnished During Emergency Period. • Directs HHS Secretary to consider ways to encourage the use of telecommunications systems, including remote patient monitoring, for home health services

SEC. 3708. Improving Care Planning for Medicare Home Health Services.

Topic	Guidance
Improving Care Planning For Medicare Home Health Services	Removes the requirement for Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs) to perform home health certifications under the supervision of a physician, allowing these advance practice providers to practice independently to the extent allowable by their state license. • In states that require physician supervision, this section will not change that requirement • The effective date is yet to be determined, but it will be no later than 6 months following enactment of CARES Act

SEC. 3709. Adjustment of Sequestration.

Topic	Guidance
Adjustment of Sequestration	• This section **temporarily lifts** the Medicare sequester, which was reducing Medicare payments to providers by 2%, from May 1 through December 31, 2020. This is a small but helpful payment increase for hospitals, physicians, nursing homes, home health care agencies, and other providers. • Some Medicare Advantage (MA) plans were also reducing their payments by 2% payment based on the Medicare sequester (and the MA plan's interpretation of their own payment rules). Managed care departments should reach out to their contracted payers to ensure that MA plans will likewise be removing any sequester reduction in their rates.

SEC. 3710. Medicare Hospital Inpatient Prospective Payment System Add-On Payment for COVID-19 Patients During Emergency Period.

Topic	Guidance
Medicare Hospital Inpatient Prospective Payment System Add-On Payment for COVID-19 Patients During Emergency Period	• This section **increases** Medicare diagnosis-related group (DRG) payments by **20%** for patients discharged with a diagnosis of COVID-19. This increase will only be available to Inpatient Prospective Payment System (IPPS) hospitals for the duration of the public health emergency. • The Secretary of HHS will provide addition guidance on how the use of diagnosis codes, condition codes, etc., will allow for this increased payment. The new ICD-10-CM coding and reporting guidelines for COVID-19 (U07.1) are effective on or after April 1, 2020.

SEC. 3711. Increasing Access to Post-Acute Care During Emergency Period.

Topic	Guidance
Increasing Access to Post-Acute Care During Emergency Period	• This section gives hospitals greater flexibility during the COVID-19 emergency to transfer patients to alternative care settings by waiving the Inpatient Rehabilitation Facility (IRF) 3-hour rule, which requires that a Medicare patient participate in at least 3 hours of intensive rehabilitation at least 5 days per week in order to be admitted to an IRF. • This section also allows a Long-Term Care Hospital (LTCH) to maintain its designation even if more than 50% of its cases are less intensive. It also temporarily halts the LTCH site-neutral payment reductions.

SEC. 3713. Coverage of the COVID-19 Vaccine Under Part B of the Medicare Program Without Any Cost-Sharing

Topic	Guidance
Coverage of the COVID-19 Vaccine Under Part B of the Medicare Program Without Any Cost-Sharing	• This section adds COVID-19 vaccine and administration as required covered preventive services and removes deductible and other patient cost-sharing requirements (related to the COVID-19 vaccine) under Part B and Medicare Advantage. • When a COVID-19 vaccine becomes available, any applicable code(s) will be automated to not require patient cost sharing.

SEC. 3718. Amendments Relating to Reporting Requirements with Respect to Clinical Diagnostic Laboratory Tests.

Topic	Guidance
Reporting Requirements with Respect to Clinical Diagnostic Laboratory Tests	• This section delays by one year the upcoming reporting period during which laboratories are required to report private sector payment rates to CMS and prevents scheduled reductions in Medicare payments for clinical diagnostic laboratory tests furnished to beneficiaries in 2021. • CY 2021 Medicare clinical laboratory fee schedule (CLFS) payment rates were previously set to see reductions of up to 15%. These potential reductions (for 2021 only) have been reduced to 0 (zero). This is significant change for provider billing under the CLFS.

SEC. 3719. Expansion of the Medicare Hospital Accelerated Payment Program During the COVID-19 Public Health Emergency.

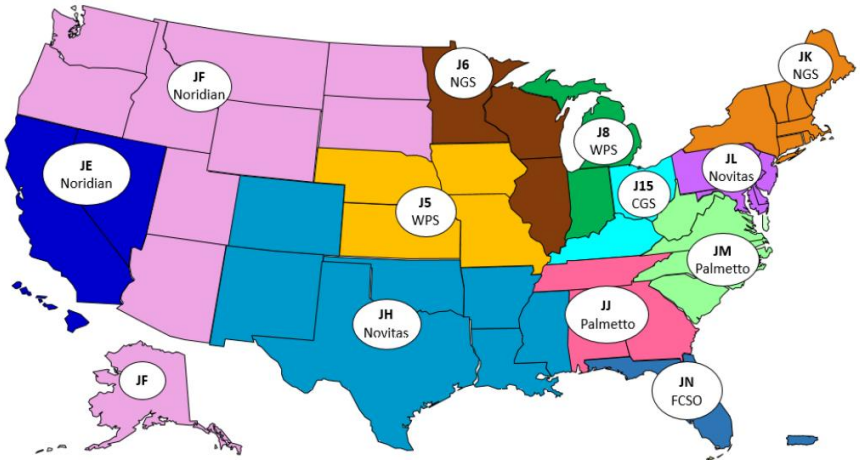
Topic	Guidance
Applicability	This section expands hospital eligibility under the existing Medicare accelerated payment program for the duration of the COVID-19 emergency period. • Eligible hospitals now include: *Critical Access Hospitals (CAHs), Children's Hospitals, and Cancer Hospitals*. • This could be significant for hospitals in rural areas who need reliable and stable cash flows to maintain an adequate workforce, buy essential supplies, and keep the doors open to care for patients during this emergency.
Hospital-specific Provisions	Hospitals may request from their Medicare Administrative Contractor (MAC): • Up to a six-month advanced lump sum or periodic payment; • Up to 120 days before claims are offset for recoupment; and • Up to 12 months from the first payment date before recoupment payments are due in full.

Accelerated Payment Options for Providers
Medicare Part A and B

Topic	Guidance
Eligibility	To qualify for advance/accelerated payments the provider/supplier must: 1. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form 2. Not be in bankruptcy 3. Not be under active medical review or program integrity investigation; and 4. Not have any outstanding delinquent Medicare overpayments.
Amount of Payment	Qualified providers/suppliers will be asked to request a specific amount using an 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 (CAH) can request up to 125% of their payment amount for a six-month period.

Where to Request an Accelerated Payment

Processing Time: Each MAC will work to review and issue payments within seven (7) calendar days of receiving the request.



MAC	Area	Request Link/Number
Noridian	AK, AZ, CA, HI, ID, MT, ND, NV, OR, SD, UT, WA, WY, AS, GU, MP	Call 1-866-575-4067
NGS	CT, IL, ME, MA, MN, NY, NH, RI, VT, WI	Link to Request Form JK J6
WPS	IN, MI, IA, KS, MO, NE	Call 1-844-209-2567
Novitas	AR, CO, DE, DC, LA, MS, MD, NJ, NM, OK, PA, TX	Link to Request Form JL JH
CGS	KY, OH	Link to Request Form J15
Palmetto	AL, GA, NC, SC, TN, VA	Links to Request Form Part A JJ JM Part B JJ JM
FCSO	FL, PR, US VI	Link to Request Form JN

For more information: CMS FAQ on the Accelerated Payment Program

SEC. 3813. Delay of DSH Reductions.

Topic	Guidance
DSH Payments	The federal government makes Disproportionate Share Hospital (DSH) payments to help offset costs of uncompensated care for many safety-net hospitals.
Reduced DSH Payments	While the Affordable Care Act (ACA) initially directed Congress to reduce DSH allotments beginning in 2014, a variety of legislation previously delayed these reductions to May 23, 2020.
DSH Changes Under CARES Act	The CARES Act is further delaying Disproportionate Share Hospital (DSH) payment reductions, which will now take effect beginning December 1, 2020.