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Michael Best Q&A on Healthcare Related Changes under the CARES Act

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On January 31, 2020, the United States Department of Health and Human Services ("HHS") Secretary declared the novel coronavirus (COVID-19) a public health emergency (PHE). On March 11, 2020, the World Health Organization declared COVID-19 a pandemic and President Trump declared a national emergency over COVID-19 two days later.

The PHE declaration empowered the HHS Secretary to temporarily modify or waive certain requirements under the Medicare, Medicaid and Children's Health Insurance Programs (collectively, the federal health programs) and the Health Insurance Portability and Accountability Act (HIPAA).

The President signed the Coronavirus Aid, Relief and Economic Security Act or the CARES Act (the Act), on March 27, 2020. The Act has a number of additional measures to support the health care provider system to respond to the COVID-19 PHE. Additionally, there are many appropriations to HHS for distribution to providers, states, localities and tribes as they respond to the COVID-19 outbreak, prepare for future PHEs and modernize the health care system.

Below is a summary of the various waivers and the Act's provisions related to health care providers and those seeking health care during the PHE.

CARES Act Provisions Relevant to Providers

What does the Public Health and Social Services Emergency Fund (the "Emergency Fund") under the Act provide to hospitals*?*

The Emergency Fund provides the following:

$100 billion to reimburse eligible health care providers for health care-related expenses or lost revenues directly attributed to COVID-19 that have not been otherwise reimbursed. Eligible providers are public entities, Medicare or

Medicaid enrolled suppliers and providers, and other for-profit and non-profit entities determined by the HHS Secretary. The HHS Secretary will provide emergency payment on a rolling basis through efficient payment systems.

What funds are available for medical surge preparation and vaccine development?

$27 billion is available through fiscal year 2024, to fund activities such as developing and purchasing vaccines and purchasing diagnostic and medical surge capacity. The Act funds workforce modernization, expanded telehealth access and other preparedness measures. A portion of these funds is earmarked for entities that are part of the Hospital Preparedness Program, and another portion will be used for purchasing products for the Strategic National Stockpile. In addition to the financial support, the Act addresses medical supply and drug shortages, requires evaluation of the national stockpiles and adds measures to prevent future shortages of essential medical supplies, devices and drugs.

Are any funds allocated for rural health or Indian Health Services?

$275 million is available until September 30, 2022, for the services administered under the Health Resources and Services Administration, with $180 million set aside to enhance telehealth and rural health activities. From this amount, $15 million is allocated to tribes and tribal organizations, urban Indian health organizations or health service providers to tribes.

What changes in the Act are related to Medicare reimbursement?

- The Act temporarily suspends Medicare sequestration from May 1, 2020 to December 31, 2020.
- During the PHE, the Act provides a 20% add-on payment to the DRG rate for patients with COVID-19.
- Hospitals may request accelerated payment for inpatient services that covers up to six months. Hospitals may request payment up to 100% (up to 125% for critical access hospitals) of what the hospital would have otherwise received. Hospitals will have up to 120 days until their claims are offset to recoup the funds, and at least 12 months before payment on the outstanding balance is due in full.

What changes in the Act are related to the Medicaid program?

- The Act eliminates a $4 billion reduction in Disproportionate Share Hospital (DSH) for FY 2020, reduces the cut for FY 2021 to $4 billion and delays the cut until December 1, 2020.
- States that did not expand Medicaid may use the Medicaid program to provide coverage to uninsured COVID-19 adults for COVID-19 related services if they would have qualified for Medicaid had the state expanded.

Must providers publish the cost of COVID-19 tests?

Providers who offer COVID-19 testing are required to list the cash price on their public internet website.

Does the Act allow any flexibility under the fraud and abuse laws to adjust physician compensation?

The Act does not address the Stark Law, Anti-Kickback statute or False Claims Act. Some hospitals and health systems may seek to adjust physician compensation due to material changes in patient volume and other circumstances caused by the PHE. Though not specifically addressed in the Act, flexibility in the existing laws allow for compliant compensation adjustments, both upward and downward depending on circumstances.

Telehealth

What is telehealth?

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. Telehealth allows patients to access routine health care, keeps patients in their homes and enables social distancing when reasonable and appropriate to protect both patients and health providers from possible virus spread. There are three reimbursement categories for telehealth services: a telehealth visit, a virtual check-in and an e-visit.

How have telehealth requirements changed during the PHE and under the Act?

Each state and the Centers for Medicare and Medicaid Services (CMS) have laws and regulations governing when and how telehealth services may be rendered and reimbursed. To expand access to care during the PHE, CMS issued a waiver addressing telehealth services for Medicare beneficiaries. The CMS fact sheet describing the waiver expands Medicare reimbursement for office, hospital, and other visits furnished via telehealth, including in patients' places of residence, starting March 6, 2020. Physicians, nurse practitioners, clinical psychologists, and licensed clinical social workers can be reimbursed under the federal health programs and under the Act for offering telehealth services to federal health program patients, patients of Rural Health Centers (RHC) and patients of Federal Qualified Health Clinics (FQHC).

Do co-pays or deductibles apply for telehealth services?

Generally, yes, but the HHS Office of Inspector General (OIG) allows health care providers to reduce or waive cost-sharing (co-pays and deductibles) for *telehealth visits* paid by federal healthcare programs. Click here for additional information. The Act allows high deductible health plans to cover telehealth services without any cost-sharing even if the plan's deductible is not met.

Moreover, the relief package passed before the Act (known as the Families First Coronavirus Response Act or FFCRA) mandates provision of COVID-19 diagnostic testing (and associated office visit - which may be a telehealth visit) without cost-sharing. See more under the question entitled "*Are health plans covering all costs associated with COVID-19 diagnosis and treatment?"*

What type of services may be provided via telehealth and for patients in their home?

In addition to COVID-19 diagnosis testing visits, common office visits (evaluation and management), mental health counseling and preventive health screenings may be provided via telehealth to federal health program patients, RHC patients and FQHC patients. The Act provides a number of measures that reduce face-to-face evaluations for dialysis patients, allow hospice recertification, facilitate community-based services and home health services and allow nurse practitioners, physician assistants and certified nurse specialists to certify home health services. A prior provider-patient relationship is not required for a telehealth service during the PHE. Providers should use the applicable HCPCS/CPT code and use the required communication modality required for the billed code. Under the Act, FQHCs and RHCs will be reimbursed at a rate similar to payment under the Medicare Physician Fee Schedule.

Is a certain technology required for telehealth services?

The provider must use an interactive audio and/or video telecommunications system that permits real-time communication between the provider's site and the patient at home. The provider must use both audio and video for a telehealth visit. Audio-only is allowed for virtual check-ins. E-visits must be conducted using a patient portal.

Do the HIPAA requirements apply to telehealth services?

With respect to HIPAA compliance, the HHS Office for Civil Rights (OCR) issued a notice of enforcement regarding discretion for telehealth communications during the PHE. This means that the *OCR will generally not enforce HIPAA security requirements and waives penalties for HIPAA violations against health care providers that serve patients in good faith through applications, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.* The OCR states that providers should enable all available encryption and privacy settings when using third-party applications, inform patients of potential privacy risks, and sign a business associate agreement with technology platform vendors. Providers should obtain a consent from patients, allowing PHI to be shared through an unencrypted manner and acknowledging that the data may be at risk to a cybersecurity incident.

HIPAA Privacy and Security

Is HIPAA compliance required during the PHE?

Yes, however, HIPAA includes an exception for health care providers to report certain diseases or conditions of an individual patient to various state and federal government agencies, including state health departments and the Centers for Disease Control and Prevention (CDC). In several bulletins available online here, the OCR provides guidance regarding patient privacy rights and how patient information may be shared, and limits to sharing patient information during the COVID-19 outbreak. Those required to comply with HIPAA should continue to apply requirements for sharing information, including the minimum necessary standard and role-based access policies to limit access to protected health information to only those workforce members who need it to carry out their duties.

HHS' March 2020 Bulletin further states that the Secretary has exercised his authority to waive sanctions and penalties against a covered hospital that does not comply with the following provisions of the HIPAA Privacy Rule:

- *the requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care.*
- *the requirement to honor a request to opt out of the facility directory.*
- *the requirement to distribute a notice of privacy practices.*
- *the patient's right to request privacy restrictions.*
- *the patient's right to request confidential communications.*

What if I am working remotely during the PHE?

A covered entity that transmits patient information should do so according to its policies and procedures related to disasters. For workforce members that do not typically telecommute, entities should assure proper training, require attestations for HIPAA compliance and install any software that employees who regularly work remotely have in place. Compliance checklist items should include secure WiFi, using a room outside of view of others in the household, and destroying paper records with a cross-cut shredder.

Coverage and Payment Related to COVID-19 and Circumstances Caused by COVID-19

Will providers be paid for COVID-19 related services?

Yes. CMS issued new HCPCS codes for health care providers who test patients for Coronavirus. Both codes can be used to bill Medicare as well as other health insurers that choose to utilize and accept the codes. CMS is not requiring any pre-authorization for testing or treatment of COVID-19, and is encouraging health plans and insurers to waive pre-authorization requirements.

What about COVID-19 related hospital quarantines and care provided to patients in an alternative site?

CMS will pay hospitals the DRG rate for patients that need to be isolated or quarantined in a private room (instead of semi-private). Patients that could be discharged but are instead remaining in the hospital under quarantine do not have to pay an additional deductible for quarantine in a hospital.

Subject to state law requirements (or waivers from HHS), CMS will reimburse hospitals for care provided at alternate sites established to treat patients during the PHE.

Will health care services provided in an alternate location be covered and reimbursed?

If a hospital adds a practice location during the PHE, it must file a Form 855A to advise CMS of this action. The hospital is not required to obtain prior approval from CMS in order to bill Medicare for services at the added location. There is also no survey requirement for added locations, but the site must comply with state law requirements unless waived by HHS.

Are health plans covering all costs associated with COVID-19 diagnosis and treatment?

Group health plans (including self-insured and ACA-grandfathered) and a health issuers offering group or individual health insurance coverage may not impose any cost share (co-pays, deductibles or co-insurance) for testing and visits to a physician, urgent care or ED related to the diagnosis of COVID-19. This means that the health plans and insurers must pay the full negotiated rate or the cash price listed for testing on provider websites. Some plans and insurers are waiving all out-of-pocket costs for ***treatment*** of COVID-19. Plans may waive treatment cost share, but are not required to do so.

Emergency Medical Treatment and Labor Act (EMTALA)

What is EMTALA and does it apply during the PHE?

CMS has provided hospitals with EMTALA compliance guidance related to COVID-19. EMTALA is legislation passed in 1986 to prevent hospitals with a dedicated emergency department ("ED") from refusing care or transferring to another facility uninsured persons seeking emergency care (including those in labor). EMTALA requires hospitals to, at a minimum:

- Provide a medical screening exam (MSE) to every individual who comes to the ED for examination or treatment for a medical condition to determine if they have an emergency medical condition defined as acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy, impairment or dysfunction;

- Provide necessary stabilizing treatment for individuals with an emergency medical condition within the hospital's capability and capacity; and

- Transfer individuals with emergency medical conditions to other hospitals in compliance with EMTALA requirements and accept transfers of individuals from other hospitals, when appropriate.

CMS's guidance alerts hospitals regarding screening, patient transfers and how to request an EMTALA waiver.

1. CMS confirms that hospitals with capacity and capability to treat patients who have COVID-19 symptoms or are diagnosed with COVID-19 must accept these patients in compliance with EMTALA. Hospitals with capacity and capability must also accept transfers of these patients from hospitals that do not have capacity or capability. A hospital's lack of an intensive care unit does not relieve a hospital of screening and stabilizing requirements under EMTALA.

2. Hospitals may use on-campus screening sites outside of the ED. Patients must be registered by the hospital and qualified personnel must direct patients not needing immediate care to screening sites.

3. Hospitals may advise the public to be screened at hospital-controlled off-campus screening sites, but a hospital may not direct people seeking emergency care at the hospital to an off-campus site. Further, hospitals may not use signage to create barriers or to direct patients off-campus after they have presented at the ED for emergency care.

4. Hospitals may request that a person wait outside or in their car after a qualified medical practitioner has determined that the person does not have signs or symptoms of needing immediate care. The hospital must monitor the person to ensure that their condition does not deteriorate to a point of needing immediate care.

5. Screening clinics developed outside of hospital control are not subject to EMTALA.

6. During the PHE, Hospitals may seek EMTALA waivers from CMS to direct, relocate and transfer individuals who come to the ED to alternative facilities.

Are hospitals required to comply with OSHA while also complying with EMTALA?

Hospitals are expected to provide adequate personal protective equipment (PPE) during the PHE. Due to known and anticipated shortages, CMS and state surveyors will not assess OSHA compliance during the PHE.

Blanket Waivers and Waiver Requests

What other waivers or relaxed rules are in place during the PHE and under the Act?

CMS has issued the following blanket waivers:

1. Skilled Nursing Facilities (SNF) – waiver of the 3-day prior hospitalization for an SNF stay for those residents transferred to the SNF as result of the PHE. Those who exhausted SNF benefits have renewed SNF coverage without having to start a new benefit period.

2. Critical Access Hospitals – waiver of the 25-bed limit and 96-hour stay limit.

3. Provider Licensure – waives requirements that providers be licensed in the state where they are providing services if they are licensed in another state. State licensure and local practice requirements may still apply if the state or territory has not requested a waiver. Most states have requested these waivers.

4. Information about other blanket waivers for long-term care acute hospitals, durable medical equipment suppliers, home health agencies, hospitals with psychiatric and rehabilitation units, provider CMS enrollment and CMS appeals is available here. Additionally, the Act addresses changes in reimbursement or requirements related to these providers.

5. States may seek waivers that correspond with those issued by CMS via email at Jackie.Glaze@cms.hhs.gov or by letter.

Do the waivers, guidance and relaxed enforcement for the federal health programs apply to non-federally funded health plans and health insurers?

Many health plans and insurers have or will adopt CMS's guidance, waivers and relaxed enforcement during the PHE. As noted above, many health plans and insurers are waiving patient/member cost share for treatment even though they are not required to do so. In addition, many providers are waiving co-pays and deductibles normally collected by the provider. If you have specific questions about how the

information in this summary applies to a health plan, health insurance or private payment requirements, we recommend that you contact the health plan, insurer or provider; review the coverage and/or plan documents or review any applicable contract.

When will the waivers, guidance and relaxed enforcement end?

Unless a waiver or guidance states otherwise or they are extended by legislation, all waivers and guidance will terminate when the PHE ends.

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