COVID-19 Related Policy Issues

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Notes:

Overview of Presentation

- 1135 Waiver overview: what triggers them and what it allows HHS to do
- Overview of current waivers, which ones have been made permanent and which waivers might still become permanent
- Overview of the Interim Final Rules with Comment and how those interact with the waivers
- Provider Relief Funding and Accelerated/Advanced Payments update
- What next?

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Notes:

COVID-19 Public Health Emergency

- Secretary of HHS first initiated a public health emergency (PHE) on January 31, 2020. President then declared a Stafford Act national public health emergency on March 13, 2020, which empowered HHS to authorize CMS to provide unprecedented flexibility for certain Medicare, Medicaid and CHIP program requirements.
- Blanket waivers allow providers to not have to apply for individual waivers under section 1135 of the Social Security Act.
- 1135 waivers apply to federal requirements only, not those established by states, and are retroactive to March 1, 2020.
- Current PHE has been extended 90 days from July 20, 2021, to go to the end of October 2021.
- New Administration has indicated PHE will last through 2021 with a 60 day advance notice before the flexibilities end (now hearing may go to middle of 2022).

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Notes:

Overview of section 1135

- Section 1135 of the Social Security Act gives the Secretary of HHS authority to waive various provisions of the Medicare and Medicaid programs when:
  - The President has declared a national emergency; and
  - The Secretary of HHS has declared a public health emergency
- Section 1135 was enacted in the aftermath of the 9/11 terrorist attacks, in large part because HHS lacked the tools to rapidly adapt Medicare and Medicaid policies in the New York/New Jersey/Washington D.C. metropolitan area in the aftermath of the attacks.
- Waivers remain in effect until the expiration of the national emergency, the public health emergency, or 60 days after becoming effective (with an option for successive extensions)

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Notes:

Section 1135 Overview

- Waiver authority is very broad in the sense that the Secretary can waive requirements of Medicare, Medicaid, and CHIP, but circumscribed in the sense that waivers are only permitted in seven broad areas:
  - Conditions of participation;
  - Physician licensure;
  - EMTALA;
  - Physician self-referral statute;
  - Deadlines and timetables for performance of required activities (modifications, not waivers permitted);
  - Out-of-network MA plan provider payment;
  - HIPAA privacy standards

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Notes:

COVID-19 Waivers

Total Number of Medicare Blanket Waivers: Over 130

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Total Number of State 1135, 1115, Disaster SPA and IT Funding Request Approvals: Over 150

https://www.Medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

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Notes:

Telehealth

- During the COVID-19 PHE CMS has significantly expanded access to health care services via telehealth to ensure continuity of care and reduce risk of transmission
- More than 150 new CPT codes have been added to the CMS Telehealth List
- Many of these new codes are authorized to be furnished via audio-only devices
- Expanded telehealth benefit available to beneficiaries in all areas (not just rural)
- Permanent changes for telehealth will apply only for established, not new, patients

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Notes:

Telehealth: PFS CY22 Proposed Rule

CMS proposing to make certain of these telehealth changes permanent in their CY 22 Physician Fee Schedule proposed rule:

- CMS wants to pay providers for giving certain mental and behavioral healthcare services to patients via audio-only telehealth calls. However, payment would only be met under certain services including counseling and therapy for opioid treatment.
- The Physician Fee Schedule eliminated geographic restrictions that could be a barrier to telehealth services for mental health. Under the rule, patients also would be able to access telehealth in their own homes.

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Notes:

Telehealth: PFS CY22 proposed rule, cont.

- If finalized, the rule would cover telehealth used for diagnosis, evaluation and treatment of mental health disorders and also would pay physicians for mental health visits delivered via telehealth to rural and vulnerable patient populations.

- CMS also proposed allowing certain services that have been added to the Medicare telehealth list to remain covered through the end of Dec. 31, 2023, so that "there is a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 [public health emergency]."

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Notes:

Additional COVID provisions in CMS Payment Rules

Hospice: CMS issued several waivers amid the pandemic, including one that allowed the use of pseudo-patients for hospice aide competency testing. The final hospice rule makes this waiver permanent.

Inpatient Psychiatric Facilities: CMS will require inpatient psychiatric facilities to report COVID-19 vaccination status of their employees. The measure was developed by the CDC to track vaccinations of healthcare personnel in the inpatient psychiatric setting.

Skilled Nursing Facilities: CMS will require skilled nursing facilities to report COVID-19 vaccination status of their employees.

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Notes:

COVID-19 Interim Final Rules

- CMS provided relief to a wide and unprecedented range of regulatory requirements to maximize the health system's preparedness in a matter of weeks when normal CMS rulemaking takes at least a year.
- Key elements of the first interim final rule with comment (IFC):
  - Provided many provider types flexibility to use telecommunications technology to visit and monitor Medicare beneficiaries
  - New payments for laboratories to collect specimens from homebound patients and inpatients (not in a hospital) for COVID-19 testing
  - Expansion of Part B ambulance coverage for the transport of patients to all facility destinations, such as community mental health centers and Federally Qualified Health Centers (FQHCs)

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Notes:

COVID-19 Interim Final Rules

Key elements of the second IFC:

- Established Medicare coverage for serology (antibody) tests
- Established separate payment to hospital outpatient departments and physician practices to collect lab samples. Medicare will also pay pharmacies who are enrolled as labs to perform tests for beneficiaries
- Further expanded access to telehealth services available for Medicare beneficiaries, including by lifting restrictions on the type of clinical practitioners that can furnish telehealth services
- Helped hospitals increase their supply of beds to manage a surge of COVID-19 patients while maintaining stable, predictable Medicare payments

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Notes:

COVID-19 Interim Final Rules

Key elements of the third IFC:

- Required long term care facilities to test facility residents and staff
- Established new requirements in the hospital and critical access hospital (CAH) conditions of participation (CoPs) for tracking the incidence and impact of COVID-19 and to report daily key COVID data points to CDC and CMS
- Established requirements for all CLIA laboratories to report COVID-19 test results to the HHS Secretary
- Revises the previous policy by establishing that each beneficiary may receive one COVID-19 test without the order of a physician or other health practitioner, but Medicare will require such an order for all further COVID-19 tests

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Notes:

COVID-19 Interim Final Rules

Key elements of the fourth IFC:

- Establishes enhanced Medicare payments for new COVID-19 treatments
- Creates flexibilities in the public notice requirements and post-award public participation requirements for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act during the COVID-19 PHE
- Creates flexibilities for states maintaining Medicaid enrollment during the COVID-19 PHE
- Takes steps to ensure price transparency for COVID-19 tests

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Notes:

COVID-19 Interim Final Rules

Fifth IFC announced in mid August by President Biden:

- Mandatory vaccinations for health care workers in federally funded SNFs
- As of September 7, 2021, IFC had not gone to OMB for review so implementation date of reg TBD
- As announced, was not intended to apply to other healthcare entities beyond SNFs that receive Medicare/Medicaid funding.

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Provider Relief Fund

Provider Relief Fund (PRF): Direct provider payments to those eligible providers who diagnose, test, or care for individuals with possible or actual cases of COVID-19, and have health care related expenses and lost revenues attributable to COVID-19.

Payments to date as of end of May 2021: $119+ billion obligated to 410,000+ unique providers paid in 650,000+ payments.

Eligible providers for General Distribution payments have included Medicare, Medicaid, and Children's Health Insurance Program participants, as well as some health care providers who are private pay or accept commercial insurance (e.g. assisted living facilities, behavioral health, and dentists). Funds have also been allocated to specific provider groups via Targeted Distribution payments, including: Hospitals in COVID-19 high impact areas, rural hospitals, and SNFs.

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Notes:

Provider Relief Fund, Cont.

PRF Terms and Conditions: Providers must attest to program Terms and Conditions in order to receive payment, such as:

- Eligible providers may use funds to prevent, prepare for, and respond to coronavirus, and for related expenses or lost revenues attributable to coronavirus.
- Funding cannot be used where another source has reimbursed or is obligated to reimburse those expenses or losses.
- Payments can be pre-payments, prospective or retrospective payments.
- Provider and payment information for entities that have attested to at least one payment is posted to an HHS Public Use File (PUF).

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Provider Relief Fund, cont.

Remaining Funds: At present, HHS has approximately $24 billion remaining in unallocated funds in the Provider Relief Fund program. Additionally, HRSA is making available $8.5 billion in American Rescue Plan Act (ARPA) funding to qualified providers serving patients in rural communities. These ARPA Rural funds will reimburse providers for health care related expenses and lost revenues that are attributable to COVID–19.

Reporting Portal: The PRF Reporting Portal was open until September 30, 2021 for recipients who received one or more payments exceeding, in the aggregate, $10,000 during Payment Received Period 1 (April 10, 2020 to June 30, 2020).

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Provider Relief Fund, cont.

Auditing of PRF payments: HRSA has engaged four contractors to help do audits of the PRF funds. Expect a lot of oversight from HHS and Congress on PRF funding including reviews by GAO and OIG.

Appeal Rights: HRSA has announced that it intends to create an appeals mechanism for disputes over PRF funding. No additional details as of September 7.

FAQs: Can be found at Provider Relief Fund General Information | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

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Notes:

Advance and Accelerated Payments - CMS

- Medicare providers and suppliers who requested and received COVID-19 Accelerated and Advance Payments (CAAPs) from CMS due to the COVID-19 Public Health Emergency (PHE) are now going to need to begin to repay them.
- Section 3719 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act expanded the existing Accelerated Payments Program to give additional flexibilities during the PHE. This included extending repayment timeframes for inpatient hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals.

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Advance and Accelerated Payments - CMS

Title V (Section 2501) of the Continuing Appropriations Act, 2021 and Other Extensions Act, enacted on October 1, 2020, amended the CAAP repayment terms for all providers and suppliers who requested and received CAAPs during the COVID-19 PHE and established a lower interest rate of 4% for any demanded overpayments to recover CAAP balances due. The CAAP repayment terms provide as follows:

- Repayment begins 1 year starting from the date CMS issued your first CAAP.
- Beginning 1 year from the date CMS issued the CAAP and continuing for 11 months, CMS will recover the CAAP from Medicare payments due to providers and suppliers at a rate of 25%.
- After the end of this 11 month period, CMS will continue to recover remaining CAAP from Medicare payments due to providers and suppliers at a rate of 50% for 6 months.

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Notes:

Advance and Accelerated Payments - CMS

- After the end of the 6 month period, the provider's Medicare Administrative Contractor (MAC) will issue the provider a demand letter for full repayment of any remaining balance of the CAAP. If CMS doesn't receive payment within 30 days, interest will accrue at the rate of 4% from the date the MAC issues the provider the demand letter.
- After that, CMS will assess interest for each full 30-day period that the provider fails to repay the balance. If the provider received an accelerated or advance payment, CMS will begin to recoup any outstanding balance from any payments due to the provider from their Medicare claims.
- This began as soon as March 30, 2021, depending upon the 1 year anniversary of when the provider received their first payment.

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