
Health Law Daily Wrap Up

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CMS has relaxed a number of requirements for Medicare and Medicaid coverage and reimbursement in the midst of the COVID-19 pandemic.

Months into the COVID-19 pandemic, health care facilities continue to face challenges in determining Medicare and Medicaid coverage and reimbursement requirements for COVID-19-related services and the multitude of other requirements that CMS has relaxed as a result of the public health emergency. With the American Hospital Association estimating that hospitals will lose $323 billion in 2020 due to COVID-19, it is more important than ever for providers to maximize reimbursement by knowing the current status of Medicare and Medicaid coverage and reimbursement requirements.

Medicare

The Coronavirus, Aid, Relief, and Economic Security Act (CARES Act) (P.L. 116-136) and two recent interim final rules (85 FR 19230, April 6, 2020; and 85 FR 27550, May 8, 2020) made a number of changes to Medicare Parts A and B coverage and reimbursement in light of the pandemic (see CMS’ FAQs for fee-for-service providers). (For further information, see Coronavirus Aid, Relief, and Economic Security Act (CARES Act) impacts health industry, health law, March 30, 2020; Health care policies slip through the CARES Act window, April 28, 2020; CMS removes barriers, increases flexibilities for providers during coronavirus pandemic, April 6, 2020; and CMS eases rules to help providers effectively respond to COVID-19, May 8, 2020.) Most of these changes apply only during the public health emergency declared by HHS Secretary Alex Azar. This declaration is currently due to expire July 25, but it will reportedly be renewed after extensive advocacy on behalf of the health care industry.

Part A. The following flexibilities to Part B coverage and reimbursement apply during the public health emergency:

- Under the hospital inpatient prospective payment system (IPPS), for the discharge of an individual diagnosed with COVID-19, CMS will increase by 20 percent the weighting factor that would otherwise apply to the diagnosis-related group (DRG) to which the discharge is assigned (Soc. Sec. Act §1886(d)(4)(C)(iv)). In addition, a sending hospital can include full-time equivalent (FTE) residents training at another hospital in its FTE count if certain conditions are met (42 C.F.R. §413.78(i)). See CMS’ fact sheet for hospitals.
- The 50 percent site-neutral payment rate under the long-term care hospital (LTCH) PPS does not apply (CARES Act §3711(b)). See CMS’ fact sheet for LTCHs and cancer hospitals.
- Certain inpatient rehabilitation facility (IRF) coverage and documentation requirements are waived, including that IRF patients must receive at least 15 hours of therapy (CARES Act §3711(a); 42 C.F.R. §412.622). CMS also updated the classification criteria in 42 C.F.R. §412.29 for a facility to be paid under the IRF PPS instead of the IPPS. See CMS’ fact sheet for IRFs.
- Hospices may provide routine home care hospice services via telehealth, and a hospice physician or nurse practitioner may conduct a face-to-face encounter required via telehealth (Soc. Sec. Act §1814(a)(7)(D)(i); 42 C.F.R. §§418.22, 418.204(d)). See CMS’ fact sheet for hospices.
The home health plan of care must include the provision of any telehealth services, including remote patient monitoring (42 C.F.R. §409.43). See CMS’ fact sheet for home health agencies.

CMS is providing temporary emergency coverage of skilled nursing service (SNF) services without a qualifying hospital stay.

Part B. CMS waives Medicare cost-sharing for COVID-19-related testing services and for a COVID-19 vaccination and its administration (Soc. Sec. Act §1833(a)(1)(DD), (b)(11), (b)(12), (cc)). In addition, the following flexibilities to Part B coverage and reimbursement apply during the public health emergency:

- Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may serve as a distant site for purposes of telehealth consultations (Soc. Sec. Act §1834(m)(8)). Further, Part B covers office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, and end-stage renal disease (ESRD)–related services furnished by an interactive telecommunications system when performed and referred by a physician or certain nonphysician practitioners (42 C.F.R. §410.78; see Telehealth has taken a giant step forward, but will the momentum continue? May 20, 2020). See CMS’ fact sheets for FQHCs and RHCs and ESRD facilities.

- CMS will continue to adjust the durable medical equipment (DME) fee schedule amounts for items and services furnished in rural and non-contiguous non-competitive bidding areas within the U.S. based on a 50/50 blend of adjusted and unadjusted rates (see 42 C.F.R. §414.210). See CMS’ fact sheet for DME.

- To fulfill the physician supervision requirement for outpatient hospital therapeutic services and incident-to services and supplies, the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or provider (42 C.F.R. §§410.26, 410.27(a)(1)(iv)(B), 410.32(b)(3)(ii)).

- A physician/nonphysician practitioner order is not required for COVID-19 and similar diagnostic tests, documentation and recordkeeping requirements are suspended for diagnostic laboratory tests, and various exceptions to the physician supervision requirements for diagnostic tests apply (42 C.F.R. §410.32). See CMS’ fact sheet for laboratories. CMS also announced that payment will nearly double for labs that use high-throughput technologies to rapidly diagnose large numbers of COVID cases.

- Various opioid use disorder treatment services can be furnished using audio-only telephone calls (42 C.F.R. §410.67(b)).

- If a resident participates in a service furnished in a teaching setting, payment is made if the teaching physician is present during the key portion of the service using audio/video real-time communications technology (see 42 C.F.R. §§415.172, 415.174, 415.180, 415.184). See CMS’ fact sheet for teaching hospitals, teaching physicians, and medical residents.

- Various waivers apply to the Medicare Diabetes Prevention Program (MDPP) (42 C.F.R. §410.79). See CMS’ fact sheet on the MDPP.

CMS also posted a fact sheet for ambulance providers.

To prioritize the care of COVID-19 patients, CMS extended the timing (from the 2021 performance period to the 2022 performance period) for certain Merit-Based Incentive Payment System (MIPS) qualified clinical data registry (QCDDR) measure requirements (42 C.F.R. §414.1400(b)(3)). Clinicians may also earn credit in MIPS for participation in a clinical trial and reporting clinical information by attesting to the new COVID-19 Clinical Trials improvement activity. See CMS’ fact sheet for physicians and other clinicians.

In addition, freestanding emergency departments have temporary approval to bill Medicare (see COVID-10 emergency prompts CMS to allow freestanding emergency departments participation in Medicare/Medicaid, April 23, 2020).

MSSP. CMS has made certain changes to the Medicare Shared Savings Program (MSSP) as a result of the pandemic. See CMS’ fact sheet on the MSSP. A survey revealed that more than half of responding accountable care organizations (ACOs) are likely to quit the program to avoid financial losses resulting from the pandemic.
Parts C and D. During the public health emergency, Medicare Advantage (MA) organizations are not permitted to charge cost-sharing for COVID-19 diagnostic tests or impose any prior authorization or other utilization management requirements with respect to the coverage of COVID-19 diagnostic tests, its administration, and specified testing-related services. Further, under CARES Act section 1313(c), MA organizations are required to cover the COVID-19 vaccine. CMS also adopted several changes to the Parts C and D 2021 Star Ratings to address the disruption to data collection and plan performance in 2020 posed by the pandemic (42 C.F.R. §§422.164(i), 423.184(i)).

Other waivers. CMS’ list of blanket waivers for specific providers that are in effect through the end of the emergency period was last updated June 25, 2020, as of the time this article was published. CMS also announced adjustments to certain Innovation Center models and posted FAQs on provider burden relief and enrollment relief.

Accelerated payment program. While CMS initially expanded the accelerated and advance payment program and delivered certain funds (see CMS provides $34 billion in funding for health care providers battling COVID-19, April 8, 2020), it suspended the program April 26.

Sequestration. CARES Act section 3709 eliminated Medicare sequestration from May 1, 2020 to December 31, 2020.

Provider Relief Fund. From the $175 billion that the CARES Act allocated to the Provider Relief Fund, HHS has distributed awards to health care providers (see Payments to rural providers, hospitals with high COVID-19 admissions arriving soon, May 4, 2020), including distributions to tribal hospitals, clinics, and urban health centers and to SNFs.

Medicaid and CHIP

State Medicaid agencies are required to cover COVID-19 diagnostic testing with no cost-sharing when administered during the public health emergency, and legislation created the uninsured COVID-19 testing eligibility group. A March 5 fact sheet describes Medicaid and Children’s Health Insurance Program (CHIP) coverage as it relates to COVID-19. CMS also published updated FAQs for state Medicaid and CHIP agencies and flexibilities under Medicaid and the Basic Health Program.

While some Medicaid providers felt disadvantaged by HHS’ distribution of relief funds, on June 9 CMS announced that it expected to distribute approximately $15 billion to eligible Medicaid- and CHIP-participating providers that had not received a payment from the Provider Relief Fund General Allocation, as well as a $10 billion distribution to safety net hospitals.

On May 14, CMS issued a guidance on the ways states can temporarily modify provider payment methodologies and capitation rates under their Medicaid managed care contracts (see CMS issues guidance on Medicaid managed care, capitation options responding to COVID-19, May 15, 2020).

Waivers. CMS has approved a number of section 1135 waivers for Medicaid and CHIP programs. See the CMS website and Kaiser Family Foundation’s tracker for current waivers.

Looking Ahead

It’s clear that the pandemic is far from over. Some states are currently reporting record increases in case numbers, and Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Disease, testified before a Senate panel that he wouldn’t be surprised if the U.S. sees up to 100,000 new COVID-19 cases a day “if this does not turn around.” Most of the coverage and reimbursement waivers currently in place will continue through the end of the public health emergency—which begs the questions of how long will the emergency last, and will Congress and/or HHS implement even more policies to ease providers’ burden. For information about earlier efforts, see Medicare, other insurers cover COVID-19 testing and related services, March 18, 2020.