THORN RUN PARTNERS
GOVERNMENT RELATIONS

Memorandum *March 31, 2020*

MEDICARE AND MEDICAID PROVISIONS IN THE CARES ACT

EXECUTIVE SUMMARY

President Donald Trump signed the Coronavirus Aid, Response, and Economic Security (CARES) Act (H.R. 748) on March 27, 2020. The $2.2 trillion package followed two other COVID-19-related packages and provides expanded unemployment insurance, tax credits for affected industries, payments to the American public, and more. It contains several provisions related to Medicare and Medicaid. Notably, it provides for COVID-19 vaccine coverage under Medicare Part B and expands telehealth availability for Medicare patients. Medicare and Medicaid provisions include:

- Expansion of Medicare coverage of federally qualified health center (FQHC) and rural health center (RHC) services provided via telemedicine;
- Allowance of certain check-ups to be provided via telemedicine;
- Delayed payment reductions for durable medical equipment and diagnostics;
- Provision of 90-day fills for Part D drugs;
- Relaxed post-acute care requirements;
- Increased and more rapid payment for hospitals; and
- A six-month extension of expiring Medicare, Medicaid, and public health programs.

CMS is currently working to implement several of the provisions contained in the bill. CMS has already issued a rule (TRP Summary) addressing the telehealth and remote patient monitoring provisions. It has also issued guidance on advance payments to hospitals. Additional guidance and rulemaking related to the CARES Act will be issued in the coming weeks.

CORONAVIRUS I AND II

The first COVID-19 bill, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (H.R. 6074) authorizes the Secretary of Health and Human Services (HHS) to waive telehealth restrictions in the Medicare program during the COVID-19 outbreak. It gives providers the ability to furnish telehealth services to beneficiaries regardless of geography for the duration of the outbreak.

The second COVID-19 bill, the Families First Coronavirus Response Act (H.R. 6201), made a technical correction to the Coronavirus Preparedness and Response Supplemental Appropriations Act to clarify that, for the purposes of establishing a relationship with a provider to waive current prohibitions surrounding the furnishing of telehealth services in the Medicare program, during the current public health emergency, furnishing a service allowable under the Medicare program, even if the program did not pay for such service, is a qualifying relationship.

The second COVID-19 bill, waives cost sharing for testing under Medicare and Medicaid. It also gives states the option to cover testing and related services for their uninsured populations at 100 percent federal medical assistance percentage (FMAP) and provides $1 billion for compensating providers for testing of uninsured individuals.

H.R. 6201 also provides states with a 6.2 percentage point increase on traditional FMAP for all medical services during the length of the Public Health Emergency. It will not apply to expansion or administrative FMAP or to CHIP's existing enhanced FMAP. Territories are provided with a 6.2 percent increase in FMAP and corresponding increase in their allotments for fiscal years 2020 and 2021. The FMAP is conditioned on state Medicaid programs covering COVID-19-related treatment, vaccines, and therapeutics at zero cost-sharing and on states not making their eligibility, methodologies or procedures more restrictive or increasing any cost sharing.

TELEHEALTH AND RURAL HEALTH

While the first COVID-19 response bill (H.R. 6074) expanded the availability of telehealth to a greater number of beneficiaries during the emergency, lawmakers determined that they needed to go further. They introduced significant flexibilities that will be in effect during the public health emergency. All of the policies discussed in this section sunset when the crisis is over, though this temporary coverage may provide evidence for the merits of a permanent expansion of telehealth coverage. CMS released a rule on March 30, 2020 that implements many of the statutory requirements with respect to telehealth.

Section 3703 of the CARES Act eliminates a Medicare requirement that a physician treating a patient via telemedicine has treated the patient in person in the past three years. The legislation also provides new flexibilities to federally qualified health centers (FQHC) and rural health centers (RHC) to provide telehealth services to Medicare beneficiaries in beneficiaries' homes. These services would be reimbursed based on fees in the Medicare Physician Fee Schedule for comparable telehealth services nationwide. In addition, any telehealth services provided during the COVID-19 emergency by FQHCs and RHCs would be excluded from calculations to determine FQHC and RHC payment.

In addition to the above, the CARES Act creates temporary flexibilities around in-person checkups and home-based services for certain Medicare beneficiaries. The legislation:

- Eliminates the requirement that periodic evaluations of home dialysis patients be conducted face-to-face, permitting them to take place via telemedicine;
- Permits physicians and nurse practitioners to conduct hospice recertification encounters via telemedicine; and
- Permits physician assistants, nurse practitioners, and clinical nurse specialists to order home health services for beneficiaries. This flexibility applies to Medicaid, as well.

The legislation directs the HHS Secretary to "consider ways to encourage the use of telecommunications systems, including for remote patient monitoring" for home health services during the emergency. A rule since issued by CMS addresses this statutory requirement.

MEDICARE PAYMENT

With the knowledge that health care providers may be squeezed by the crisis, Congress passed a number of policies designed to boost payments to providers and accelerate payments during the COVID-19 emergency. The Budget Control Act of 2011 (S. 365, 112th Congress) reduced payments to Medicare providers across the board by two percent. The CARES Act temporarily lifts this "sequester," beginning May 1, 2020 and ending December 31, 2020. It also extends the mandated sequestration period by one year, to 2030 rather than 2029. For extra assistance to hospitals affected by COVID-19, the legislation creates an add-on payment that applies a 20 percent payment increase for inpatient care for individuals admitted with COVID-19 during the emergency period.

The legislation delays two scheduled payment reductions in the Medicare program. Scheduled payment reductions for durable medical equipment (DME) described in the calendar year 2019 Medicare End-Stage Renal Disease (ESRD) prospective payment system (PPS) payment rule are put on hold for the duration of the emergency. Additionally, the Protecting Access to Medicare Act (H.R. 4302, 113th Congress) phases in payment reductions to transition from using private payor rates. The CARES Act stops these reductions for 2021 and lengthens the phase-in by one year, to 2024.

The CARES Act expands the Medicare hospital accelerated payment program for the duration of the emergency. Under the expansion, hospitals can elect to receive up to 100 percent of prior period payments for six months in an advance lump sum or periodic payment. Critical access hospitals are eligible to receive up to 125 percent of prior period payments. These advance payments would be required to be repaid, with the first payment being four months after receipt of the advance. Hospitals would have at least twelve months to repay the advance without accruing interest. CMS has issued guidance on this accelerated payment.

Finally, the legislation waives certain requirements for post-acute care payment in Medicare to provide flexibility and mitigate capacity shortages in acute care hospitals. The legislation:

- Waives the rule that inpatient rehabilitation facilities (IRF) patients to participate in at least three hours of intensive rehabilitation at least five days per week;
- Allows long-term care hospitals (LTCH) to maintain the designation even with a lower-intensity case mix; and
- Pauses LTCH site-neutral payment methodology.

DIAGNOSTIC AND VACCINE COVERAGE

At the outset of the crisis, it appeared as though an eventual vaccine for COVID-19 would be covered by Medicare Part D plans. The CARES Act provides for Part B coverage with zero cost-sharing of an

eventual vaccine to prevent COVID-19. This brings COVID-19 vaccination coverage in line with influenza vaccination coverage for the Medicare program.

The legislation also contains two technical fixes to clarify that under H.R. 6201, uninsured individuals may receive COVID-19 testing with no cost-sharing in states that elect to provide such a benefit through their Medicaid program, and Medicare beneficiaries can receive all COVID-19 tests under Medicare Part B with zero cost-sharing.

Access to Care and Medication

The CARES Act requires Medicare Part D plans to provide up to a 90-day supply of a covered medication at beneficiaries' request during the emergency period. However, there are exceptions. The 90-day supply requirement does not override cost and utilization management, medication therapy management, or other such programs. Additionally, fills may not be inconsistent with safety edits. Safety edits include drug interactions and potentially incorrect dosages. They also include restrictions on supplies for opioid-naïve patients.

The legislation also allows for Medicaid programs to pay for Section 1915 home- and community-based services (HCBS) as well as HCBS provided under an 1115 waiver for beneficiaries during hospital stays. This provision appears to be permanent.

Expanded FMAP

H.R. 6201 provided a supplemental 6.2 percentage points of federal medical assistance percentage (FMAP) for state Medicaid programs, subject to a number of maintenance of effort (MOE) provisions. The CARES Act contains a narrow carve-out — seemingly only applicable to Wisconsin — for premium increases for certain Medicaid beneficiaries that were already in effect when H.R. 6201 was signed into law.

The MOE requirements from H.R. 6201 state that to receive FMAP, states may not:

- Implement any eligibility standards, methodologies, or procedures that are more restrictive than those in effect in the state on January 1, 2020. This MOE requirement already applies to children through the end of fiscal year 2027;
- Impose new or increased premiums on any beneficiary that exceed the amount of the premium in effect as of January 1, 2020, *unless the premium increase was in effect when the legislation was signed into law*;
- Disenroll any individual who is enrolled as of March 18, 2020 (the date of enactment) or who newly enrolls during the public health emergency period for any reason unless the individual is no longer a resident of the state or requests voluntary termination; or
- Fail to cover, without cost-sharing, testing services and treatment for COVID-19 in Medicaid, including vaccines, specialized equipment, and therapies.

EXTENDERS

Medicare, Medicaid, and public health programs that were set to expire on May 22, 2020 were reauthorized through November 30, 2020. This maintains the status quo with respect to these programs until after the 2020 election. Over the 116th Congress, these programs have received several short-term extensions, most recently a five-month extension in an end-of-year package to fund the government in fiscal year 2020. House Speaker Nancy Pelosi (D-CA) secured the short-term extension to ensure that health care remained on Congress' agenda to attempt to force consideration of drug pricing or surprise billing legislation.

APPROPRIATIONS

The appropriations division of the CARES Act provides $200 million for the Centers for Medicare and Medicaid Services to prevent, prepare for, and respond to COVID-19. $100 million is dedicated to a survey and certification program for infection control, with a focus on nursing homes in areas with community spread.