# AASM COVID-19 Health Policy and Legislative Update Supplement

The Federal government has announced dozens of regulatory and financial changes to help health care providers during the COVID-19 Public Health Emergency. This document outlines the major financial opportunities, new waivers and authorizations, tax provisions, and legal changes that impact health systems. It is designed to help you track the major changes. It will be updated as developments warrant. For additional information contact policy@aasm.org

Please note that most of these changes apply to multiple entities within a health system, i.e. acute, post-acute, physicians, insurance. For a one-page CMS overview of major regulatory changes, click here. CMS has a user-friendly page of all the waivers for providers, containing site-specific fact sheets and multiple FAQs, click here.

| Funding, Grants, and Loans | | | |
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| **What is it?** | **What does it do?** | **Key Points** | **Entities Effected** |
| Accelerated, Advanced Payments | Section 3719 of the CARES Act enables hospitals to receive accelerated, advanced payments from the Medicare program.<br>▪ Most hospital types could elect to receive up to 100 percent of the last 6 months payments, with Critical Access Hospitals able to receive up to 125 percent.<br>▪ A qualifying hospital would not be required to start paying down the advance for four months and would also have at least 12 months to complete repayment without a requirement to pay interest.<br>▪ Please note that 12 months after payment is received, an interest rate of 10.25 percent will be put into place. | The Senate Finance Committee has a FAQ that is helpful with basic questions, click here.<br><br>CMS released a press statement stating that $34 billion had already been awarded, click here.<br><br>On April 27th, CMS stated that it was reevaluating the accelerated payment program, following payments of over $100 billion to healthcare providers and in light of the $175 billion recently appropriated for healthcare provider relief payments.<br>• Click here for the updated fact sheet on the program. | Acute Care Facilities<br>Post-Acute<br>Physicians |
| $100B Provider Grants – CARES Act (COVID legislation #3) | CARES Act includes $100 billion for hospitals and other health care providers impacted by the current pandemic in the Public Health Emergency Fund. | ▪ The initial $30 billion in payments were dispersed on April 10th, the amount provided is about 6% of FY19 Medicare fee-for-service payments.<br>http://hhs.gov/providerrelief | Acute Care Facilities<br>Post-Acute<br>Physicians |

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| | ▪ Neither the underlying law nor the language in the bill give explicit direction on how the funding will be distributed, it is at the discretion of the Secretary.<br>▪ For a one-page summary from SHC, click here.<br>▪ The first $30 billion was dispersed on April 10th, the Administration is working on targeted distributions for the remaining $70 billion that will focus on providers in areas particularly impacted by the COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of uninsured Americans.<br>o For the HHS notice, click here.<br>o For the state-by-state breakdown of the funds, click here.<br><br>Additional information on the breakdown of the funds was provided by HHS, click here.<br><br>For more on payments for uninsured from this fund, click here. And to providers can register for the program on April 27, 2020, and begin submitting claims in early May 2020, click here.<br>• HHS opened the portal to begin submitting claims for the uninsured COVID-19 patients, click here.<br>• FAQs for how to utilize the portal, click here.<br>o Please note this fund will consider people covered by short-term plans as insured, which means CARES Act dollars cannot be used to reimburse providers for those individuals' COVID-19 treatment, yet short-term plans will not be viewed as insurance when it comes to COVID-19 testing and thus providers can get federal relief money for enrollees' testing | ▪ Within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment.<br>▪ The portal for signing the attestation is now open, click here.<br>▪ Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. Total FFS payments were approximately $484 billion in 2019.<br>o A provider can estimate their payment by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments they received by $484,000,000,000, and multiply that ratio by $30,000,000,000. Providers can obtain their 2019 Medicare FFS billings from their organization's revenue management system.<br>▪ The automatic payments will come to providers via Optum Bank with "HHSPAYMENT" as the payment description<br>▪ As a condition, providers are obligated to abstain from "balance billing" any patient for COVID-related treatment<br>▪ HHS distributed the second round of payments with the total of both payments combined is approximately $20B. (This is in addition to the $30B in grants already paid.) HHS will use government data and 'true up' providers with additional payments with an emphasis on Medicaid-heavy providers and Medicare Advantage. There will also be some funds for specialty physician groups that were 'literally put out of business.'<br>▪ The next rounds will be at least one or two more coming from the $100B fund. The first will be focused payments for those with Covid-19 diagnosed patients. Providers received a request for information earlier this month, note that HHS states that while responding to the request for information is | |

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| | | NOT mandatory, it will determine where HHS is going to send the "hot spot" grants. In other words, if you don't provide the requested info, you are not likely to receive any "hot spot" grants.<br>▪ Facilities submitted data via data, site administrator received an email from HHS on Sunday April 12th, or thereafter, with instructions and a link to register on this portal. If you have not already done so, please register on this portal as directed in the email.<br>▪ If it is not clear who within your organization received this notification, or if you have questions about the registration process, please contact TeleTracking Technical Support at 877-570-6903. | |
| $75 Billion Paycheck Protection Program and Health Care Enhancement Act (COVID Bill #3.5) | On April 24th, the President signed a bill come to be known as COVID Bill #3.5 which plussed up funds from the CARES Act including the $100 Billion to increase it to a total of $175 billion in the fund. | ▪ H.R. 266 added $75 billion to the program, click here for the summary, here for the legislation. | |
| Funding - FEMA | FEMA funds available for emergency medical care activities.<br>▪ Click **here** for the Emergency Medical Care Fact Sheet for guidance | States and non-profits may apply. Even if your state applies, your organization may also apply.<br>▪ Click here for details on the FEMA program.<br>▪ There is an online application (click here), but you need to set up a name/password from your local emergency agency to get it started.<br>▪ Filing period open for the duration of the Public Health Emergency unless FEMA determines otherwise. | Acute Care Facilities<br>Post-Acute<br>Physicians |
| Funding-Medicare Sequestration | CARES Act temporarily lifts sequestration Medicare sequestration from May 1 through December 31, 2020. | This should be an automatic payment change, should not require providers to do anything to receive the higher payment<br>• CMS issued a guidance document on the increased payments, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians |
| Funding – COVID Patient Payment Increase | CARES Act increase the hospital payment by 20 percent for patients admitted with COVID-19. | Please be sure to use the proper coding (click here) for these patients to receive the higher patients. | Acute Care Facilities<br>Post-Acute<br>Physicians |

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| | | CMS also recommends that providers make notations that the patient is a COVID-19 patient or potential COVID-19 patient to ensure proper payment | |
| Funding – $500B Federal Reserve Programs | Section 4003 of the CARES Act authorizes $500 billion to backstop Federal Reserve programs and lending facilities as well as provide direct loans and facilitate private lending through the strategic use of guarantees to aviation, national defense industries and businesses generally:<br>▪ $454 billion in loans for qualifying businesses, states and municipalities Click here for general guidance.<br>o The law encourages the Department of Treasury to establish a lending program specifically for organizations with between 500 and 10,000 employees, including nonprofits.<br>o The Treasury Secretary is given broad authority to determine the terms of the transactions subject to several guideposts in the statute regarding limitations and eligibility.<br>o Further details on the program have yet to be provided by Treasury. | ▪ Treasury to provide additional guidance. Until guidance is issued, it is unclear whether hospitals may participate.<br>▪ Loans to mid-sized businesses will bear an interest rate not higher than 2 percent per year; for the first six months after the loan is made, or for such longer period as the Secretary of Treasury may determine, no principal or interest shall be due and payable.<br>▪ The CARES Act does not specify a maximum loan amount or the terms for loans made to mid-sized businesses.<br>▪ Limits compensation increases and severance payments for officers and employees of loan recipients who received total compensation in excess of $425,000 in calendar year 2019. Some conditions may be waived by Treasury.<br>▪ Eligible borrowers under the mid-sized business lending program will be required to certify to the following items:<br>o The uncertainty of economic conditions as of the date of the application that makes the loan necessary for the support of ongoing operations;<br>o The funds received will be used to retain at least 90 percent of the recipient's workforce, at full compensation and benefits, until Sept. 30, 2020;<br>o The recipient intends to restore no less than 90 percent of their workforce that existed as of Feb. 1, 2020, and to restore all compensation and benefits to their employees no later than four months after the termination date of the coronavirus public health emergency;<br>o The recipient is an entity or business that is domiciled in the United States with significant operations and a majority of its employees based in the United States; | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |

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| | | ○ The recipient is not a debtor in a bankruptcy proceeding; and<br>○ The recipient will not outsource or offshore jobs for the term of the loan and two years after completing repayment of the loan.<br>The Treasury Department released a press release on the Federal Reserve loan program which is available for mid-sized businesses, click here. Click here for a notice from the Federal Reserve on the Main Street Lending Program.<br><br>• Treasury will make a $75 billion equity investment in a special purpose vehicle established to implement the Main Street Business Lending Program<br>• Companies that participate in the PPP may also participate in the Main Street Program.<br>• Up to 10K employees and less than $2.5B in 2019 revenue.<br>• First come, first served. Applications to be made through banks and other lenders authorized to process loans; applications not yet available.<br>• 4-year term with principal and interest deferred for first year; minimum loan amount of $1M.<br>• Borrow required to make "reasonable efforts" to maintain payroll and retain employees; funds may not be used to repay or refinance existing loans and lines of credit. | |
| $185M HRSA Grants | Funds included in the CARES Act to support rural and critical access hospitals | • Grants will be awarded to states through the Small Rural Hospital Improvement Program (SHIP) grant mechanism, through HRSA's Office of Rural Health Policy.<br>• Award amounts expected to be approximately $90,000 per hospital in each state. | Acute Care Facilities |

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| | | • HRSA expected to issue notice of award for the SHIP COVID-19 funds by the first week of May.<br>$165 M in awards for Rural Telehealth and Small Rural Hospital Improvement were distributed the week of April 20th – Click here | |
| $100M HRSA Grants | Funds included in the Families First Coronavirus Response Act for community health centers | Click here for details from HRSA<br>Click here for the bill.<br>HRSA virus specific FAQs, click here - updated 4/22/2020 | Acute Care Facilities |
| FCC $200 Million in Telehealth Grants | Funded through the CARES Act, the FCC's COVID-19 Telehealth Program, will help healthcare providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. Funding applications from healthcare providers will be processed on a rolling basis. | Click here for the press release and here for the Report and Order. See pages 14-16 for details on the application process.<br>• For FCC's live portal to apply for funding click here.<br>• Click here for more information<br>• Click here for the application instructions<br>• Click here for an FAQs on the program. | |
| $100 Million in Connected Care Pilot Project | This separate three-year Pilot Program will provide up to $100 million of support from the Universal Service Fund (USF) to help defray health care providers' costs of providing connected care services and to help assess how the USF can be used in the long-term to support telehealth. | Click here for the Report and Order – the Pilot Program begins on page 37. | |
| Funding - Employee Retention Credit | The Treasury Department and the Internal Revenue Service launched the Employee Retention Credit, designed to encourage businesses to keep employees on their payroll. Applies to businesses that have been fully or partially suspended by Government order due to COVID-19. | The refundable tax credit is 50% of up to $10,000 in wages paid by an eligible employer whose business has been financially impacted by COVID-19. Click **HERE** | |
| Funding -SBA Loans for Paycheck Protection | Paycheck Protection Program – for business with less than 500 employees<br>▪ Click here for a fact sheet from the Treasury Department<br>▪ Click here for the final application posted 4/2/20<br>▪ Click here for the Interim Final Rule (UPDATED 4/14/20)<br>▪ Click here for the interim final rule on affiliation.<br>▪ Click here for affiliation rules.<br>▪ Click here for FAQs updated 4/26/20.<br>▪ Click here for how to calculate loans (4/24/20) | Eligibility:<br>▪ For-profit and nonprofit organizations (public/governmental hospitals/health systems do not quality)<br>▪ Fewer than 500 total employees (both full and part time).<br>▪ SBA will apply "affiliation rules" to determine whether an organization is under common ownership and, if so, whether the combined employee count of all affiliated entities is under 500 employees<br>Amount: The lesser of -<br>▪ 2.5 times the amount of average monthly payroll costs, excluding compensation | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |

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| | ▪ Health care and social assistance received 11.65% of approved loans. Click here for loans approved by state/sector (4/16/20)<br><br>▪ Resources - SBA Paycheck Protection Program website,<br>▪ Department of the Treasury CARES Act website<br>▪ Click here for a full description of the loans from the Senate Small Business Committee.<br>▪ Application deadline 6/30/20.<br>▪ On April 24th, the SBA clarified that public hospitals are eligible for the loans, after lawmakers urged the agency overseeing the stimulus program to make an exception for rural health providers, click here for the actual guidance from the Small Business Administration. **See Page 6** | above an annual salary of $100K, and $10 million<br>Use of Funds<br>▪ Salaries and benefits, including state and local taxes;<br>▪ Rent, utilizes and mortgage interest; and<br>▪ Interest on existing debt<br>Terms<br>▪ Payments may be deferred for 6 months but interest accrues | |
| Cash -Payroll Tax Delay | Section 2302 of the CARES Act allows employers to defer payment of the 6.2% FICA tax.<br>• Employers may defer the deposit and payment of the employer's share of social security taxes and self-employed individuals to defer payment of certain self-employment taxes. | Eligibility:<br>▪ All employers, regardless of type (e.g., for-profit, nonprofit, public/governmental) are eligible, except for those that have received and had forgiven a loan under the Paycheck Protection Program<br>Amount:<br>▪ Employers can defer payment of the 6.2% FICA tax, which is applied to wages below $137,700 in 2020 (April-Dec 2020)<br>Terms:<br>▪ Payroll taxes must ultimately be paid, with 50% due by 12/31/21 and the remaining 50% due by 12/31/22.<br>▪ No restrictions on use of money saved.<br>The IRS posted FAQs - Deferral of employment tax deposits and payments through December 31, 2020, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| FMAP - Increases Federal Share | The Families First Coronavirus Response Act provides a temporary 6.2 percentage point increase to each qualifying state's FMAP effective January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency terminates. | CMS answers some very specific questions about how this is expected to work, click here.<br>Recommend lobbying your state to assure funding is directed to providers.<br>• This was intended for Governors to allow for Medicaid to cover uninsured COVID-19 related expenses but has not been implemented as such yet. | Acute Care Facilities<br>Post-Acute<br>Physicians |

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| SAMHSA Grants for Substance Abuse and Mental Health | SAMHSA is distributing $110 million to help patients with substance use disorders and serious mental illness receive the treatment they need during the COVID-19 pandemic | The grants total $110 million and will provide up to $2 million for successful state applicants and up to $500,000 for successful territory and tribal applicants for 16 months. For information about the emergency grants, click here.<br>• For a list of recent grantees and to apply for the program, click here. | Hospitals<br>Physicians |
| CDC Medical Coding Guidelines | CDC released the official guidelines for the new ICD-10-CM code that are now in effect through Sept. 30.<br>▪ These codes will help capture and report surveillance data for the virus. | CDC issued the coding guidelines, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| The DR Condition Code | The DR Condition Code – the DR condition code is used for institutional billing only.<br>▪ Use of the DR condition code is required effective August 31, 2009 when a service is affected by an emergency or disaster and Medicare payment for such service is conditioned on the presence of a "formal waiver". | ▪ Use of the DR condition code also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.<br>▪ The DR condition code tag is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| The CR Modifier | The CR modifier is used for Part B items and services only but may be used in either institutional or non-institutional billing.<br>▪ Use of the CR modifier is required effective August 31, 2009 when an item or service is impacted by an emergency or disaster and Medicare payment for such item or service is conditioned on the presence of a "formal waiver".<br>▪ Use of the CR modifier also may be required when either the contractor or CMS determine that such use is needed to efficiently and effectively process claims or to otherwise administer the Medicare fee-for-service program.<br>▪ A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. | In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary's declaration (if any);<br>▪ specify the geographic areas affected by any declarations of a disaster or emergency;<br>▪ specify what formal waivers and/or informal waivers, if any, have been authorized;<br>▪ specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and<br>▪ specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| CMS documents on coding in Public Health Emergency | Documents from CMS on coding in Public Health Emergency | FAQ is pretty comprehensive and links to quite a few related documents, click here<br>• Factsheet on Medicare reimbursement, click here | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |

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| Medicare Fee-For-Service | Provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 | FAQs addressing payment for specimen collection, diagnostic laboratory services, hospital services, ambulance services, rural health clinics and FQHCs, expansion of virtual communications for RHCs/FQHCs, Medicare telehealth, physician services, opioid treatment services, inpatient rehabilitation facility services, skilled nursing facility services and more, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians |
| Medicaid 1135 Waivers | CMS is rapidly approving 1135 waivers to give states flexibilities to focus their resources to provide the best possible care for their Medicaid beneficiaries in response to the coronavirus outbreak. | For the most up to date list of waivers, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| CMS Waivers for "Frontline Staff" | CMS) temporarily suspended a number of rules so that hospitals, clinics, and other healthcare facilities can boost their frontline medical staffs during COVID-19 pandemic, click here | • Doctors can now directly care for patients at rural hospitals, across state lines if necessary, via phone, radio, or online communication, without having to be physically present by remotely coordinating with nurse practitioners at rural facilities.<br>• Nurse practitioners, in addition to physicians, may now perform some medical exams on Medicare patients at skilled nursing facilities whether COVID-19 related or not.<br>• Occupational therapists from home health agencies can now perform initial assessments on certain homebound patients, freeing home-health nurses to do more direct patient care.<br>• Hospice nurses will be relieved of hospice aide in-service training tasks so they can spend more time with patients.<br>Click here for the full lists of waivers. | |
| FDA Waiver for Hospitals to Compound Sedatives | Hospitals may compound a range of sedatives used for COVID-19 patients in a bid to ward off shortages during the public health emergency. | This temporary relaxation of the compounding rules will allow hospitals to make their own copies of pre-mixed drugs and portion out the drugs themselves.<br>• Drugs such as forms of fentanyl, hydromorphone and ketamine that are used to aid people on ventilators<br>• For more from the FDA, click here. | Hospitals |
| CDC Surge Tool | The CDC developed a tool to estimate hospital surge capacity. | CDC released COVID19Surge, which is a spreadsheet-based tool that hospital | Hospitals<br>Physicians |

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| | | administrators and public health officials can use to estimate the surge in demand for hospital-based services during the COVID-19 pandemic.<br>• A user of COVID19Surge can produce estimates of the number of COVID-19 patients that need to be hospitalized, the number requiring ICU care, and the number requiring ventilator support. The user can then compare those estimates with hospital capacity, using either existing capacity or estimates of expanded capacity<br>• Click here for the tool. | Post-Acute |
| CMS Hospitals Without Walls | Increase Hospital Capacity, click here. | ▪ Healthcare systems and hospitals may provide services in locations beyond their existing walls to help address the urgent need to expand care capacity and to develop sites dedicated to COVID-19 treatment.<br>▪ Hospitals will be able to transfer patients to outside facilities, such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving hospital payments under Medicare.<br>▪ Ambulances may transport patients to a wider range of locations when other transportation is not medically appropriate including community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers, and any locations furnishing dialysis services when an ESRD facility is not available.<br>▪ Healthcare systems, hospitals, and communities may set up testing and screening sites exclusively for the purpose of identifying COVID-19 positive patients in a safe environment.<br>▪ Hospital emergency departments may test and screen patients for COVID-19 at drive-through and off-campus test sites.<br>▪ Medicare will pay laboratory technicians to travel to a beneficiary's home to collect a specimen for COVID-19 testing. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |

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| Ventilators and Respirators | The Assistant Secretary of Health and the US Surgeon General addressed strategies for optimizing ventilator use including use of guidance on co-venting.<br><br>OSHA issued interim enforcement guidance on reusing disposable N95 filtering face piece respirators (N95 FFRs) that have been decontaminated. | Ventilation of two patients with one ventilator should only be considered as an absolute last resort, but for those clinicians in crisis situations, the letter outlines how ventilator splitting can be performed strictly for two patients who are both either infected or free of the virus.<br>▪ Click here for the letter.<br><br>The N95 FFR guidance applies to workplaces where workers need respirators to protect against exposure to infectious agents that could be inhaled into the respiratory system, including during care of patients with suspected or confirmed coronavirus and other activities that could result in respiratory exposure to SARS-CoV-2, the virus that causes the coronavirus.<br>• Click here for press release and here for interim enforcement guidance (4/24/20). | Acute Care Facilities<br>Post-Acute<br>Physicians |
| Interoperability and Patient Access final rule delayed | On April 22nd, CMS announced that it will delay the Interoperability and Patient Access final rule | ▪ Recognizing that hospitals, including psychiatric hospitals, and critical access hospitals, are on the front lines of the COVID-19 public health emergency, CMS is extending the implementation timeline for the admission, discharge, and transfer (ADT) notification Conditions of Participation (CoPs) by an additional six months.<br>▪ In the version of the rule displayed on March 9, 2020 on the CMS website, it stated these CoPs would be effective 6 months after the publication of the final rule in the Federal Register. CMS has changed this in the final rule will now be effective 12 months after the final rule is published in the Federal Register.<br>Click here for more from CMS. | Hospitals |
| CMS IRF | CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") | May be used if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.<br>• Click here for CMS blanket waivers (updated 4/22/2020) | Post-Acute<br>Physicians<br>Insurance |

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| CMS LTCH | CMS will allow LTCHs to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs. | Click here for CMS blanket waivers (updated 4/22/2020) | Post-Acute<br>Physicians<br>Insurance |
| Waive 3-Hour IRF Rule | Section 3711 of the CARES Act | ▪ Waives IRF 3-hour rule, which requires that a beneficiary be expected to participate in at least 3 hours of intensive rehabilitation at least 5 days per week to be admitted to an IRF.<br>▪ Allows LTCHs to maintain their designation even if more than 50 percent of their cases are less intensive and temporarily pauses the current LTCH site-neutral payment methodology.<br>▪ Click here for CMS blanket waivers (updated 4/22/2020) | Post-Acute<br>Physicians<br>Insurance |
| 3-Day SNF Rule | CMS waived the rule requiring 3-day qualifying hospital stay applies to all SNF-level beneficiaries under Medicare Part A | For FAQs on SNF waivers and requirements, click here.<br>• CMS clarified that the waiver for the SNF 3-day rule also applies to swing beds in critical access hospitals and rural hospitals<br>• Click here for CMS blanket waivers (updated 4/22/2020) | Hospitals (Including CAHs)<br>Post-Acute |
| SNF COVID Transparency Regulations | New regulatory requirements that will require nursing homes to reinforce an existing requirement that nursing homes must report communicable diseases, healthcare-associated infections, and potential outbreaks | CMS issued new regulations on April 19th that will require SNFs to –<br>• report cases of COVID-19 directly to the CDC<br>• inform residents, their families and representatives of COVID-19 cases in their facilities<br>• augment longstanding requirements for reporting infectious disease to State and local health departments<br>• require nursing homes to fully cooperate with CDC surveillance efforts around COVID-19 spread<br>CDC will be providing a reporting tool to nursing homes that will support Federal efforts to collect nationwide data to assist in COVID-19 surveillance and response.<br><br>Click here for more from CMS. | Post-Acute |

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| Elective Surgeries | CMS recommends non-essential surgeries including oral health procedures providers should postpone. Here<br>On April 19, CMS issued subsequent guidance to restart care that had been postponed, e.g., elective surgeries. Here | ▪ These are recommendations only.<br>▪ The April 19 updated guidance is based on whether a state or region has passed the Gating Criteria announced on April 16. | Acute and ASC Facilities |
| ASCs Enrolling as Hospitals | In an effort to expand hospital capacity, CMS released guidance for ASCs that explains how they are allowing Medicare-enrolled ASC's to temporarily enroll as hospitals and provide hospital services to help address the urgent need to increase hospital capacity to take care of patients. | ▪ Guidance for Processing Attestations from Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals during the COVID-19 Public Health Emergency, click here. | |
| EMTALA | CMS issues a March 13 waiver providing hospitals and related providers flexibility in transferring COVID-19 patients. Here Click here for CMS blanket waivers (updated 4/22/2020) | ▪ These waivers concern generally screening, testing sites, use of telehealth and appropriate transfers | Hospitals, CAHs and dedicated emergency rooms |
| MACRA Reporting | CMS is applying its extreme and uncontrollable circumstances policy to MACRA MIPS eligible clinicians and liberalizing quality reporting requirements. Here | ▪ These waivers relax MIPs reporting requirements and timely payment standards. | Part B Physicians |
| MACRA Performance Bonus | CMS is encouraging clinicians participating in QPP, such as physicians, physician assistants, nurse practitioners, and others, to contribute to scientific research and evidence to fight COVID-19.<br>• Clinicians in MIPS will receive credit for participation in a clinical trial and reporting clinical information by attesting to the new COVID-19 Clinical Trials improvement activity | ▪ To receive credit for the new MIPS COVID-19 Clinical Trials improvement activity, clinicians must attest that they participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study<br>▪ There is flexibility in the type of clinical trial, which could include the traditional double-blind placebo-controlled trial to an adaptive or pragmatic design that flexes to workflow and clinical practice<br>▪ Clinicians who report this activity will automatically earn half of the total credit needed to earn a maximum score in the MIPS improvement activities performance category, which counts as 15 percent of the MIPS final score.<br>▪ Click here for more from CMS. | Hospitals<br>Physicians |
| Surveys/ Audits | CMS is suspending non-emergency federal and state surveys. CMS is reprioritizing the audit activity for Medicare Advantage organizations, Part D sponsors, Medicare-Medicaid Plans, and PACE organizations. Here | ▪ This policy has wide-ranging application including RADV activities. | Acute and Post-Acute |
| CMS delay of filing deadline | SHC reached out to CMS regarding audits of cost reports by MACs, CMS responded – | The Medicare Administrative Contractors (MACs) have been instructed to suspend requests | |

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| of certain cost report due dates | CMS is currently authorizing delay for the following fiscal year end (FYE) dates.<br>▪ CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020.<br>▪ CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020. | for documentation for the following Medicare Cost Report activities:<br>1. Cost Reports Worksheet S-10 (W/S S-10) audits for all cost reports that begin during Federal Fiscal Year (FY) 2018 for hospitals that qualify for Disproportionate Share Hospital (DSH) payment until May 15, 2020. As for documentation requests that have already been sent out to the providers, MACs shall extend the documentation due date to May 15, 2020.<br>2. All Medicare Desk Reviews, Audits and Reopenings until May 15, 2020. MACs shall work on any in-house Desk Reviews, Audits and Reopenings based on the documentation that they have already received. If additional information is needed to complete the reviews, MACs shall not send any information requests before May 16, 2020.<br><br>Additional information regarding temporary waivers and flexibilities for hospitals can be found in the document entitled "Hospitals-CMS Flexibilities to Fight COVID-19," click here. | |
| Long-Term Care Facility Transfer Guidance | On April 13 CMS issued guidance that allows two or more LTC facilities to transfer/discharge patients for the purposes of co-horting without approval, however, a transfer by a certified LTC facility to a non-certified LTC requires state approval. Here | ▪ This guidance supplements related April 2 guidance. Here<br>▪ Click here for CMS blanket waivers (updated 4/22/2020) | Post-Acute |
| Medicaid 1135 Waivers | CMS is rapidly approving 1135 waivers to give states flexibilities to focus their resources to provide the best possible care for their Medicaid beneficiaries in response to the coronavirus outbreak. | For the most up to date list of waivers, click here. | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |
| Private Plans Testing Coverage | The Families First Coronavirus Response Act requires private health plans to provide coverage for COVID-19 diagnostic testing.<br>• Per the CARES Act, CMS on April 11 issued guidance to ensure no cost diagnostic testing and related services provided by private health | Includes the cost of a provider, urgent care and ED visits to receive testing. For the bill language here, (a Kaiser Family Foundation summary is here).<br>• Beyond no cost sharing testing (including anti-body testing), are urgent | Acute Care Facilities<br>Post-Acute<br>Physicians<br>Insurance |

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| | insurance. The press release is here, and the guidance document, here.<br><br>AHIP created a website listing major health insurers and their coverage of COVID-19 issues, click here. | care visits, ED visits, and in-person telehealth visits to the doctor's office.<br>• CMS - FAQs re coverage for testing, ancillary services and copays – click here for the guidance document and here for the press release | |
| CMS Medicare Changes | CMS has made to date several COVID-19-related Medicare benefit changes.<br>▪ For example, Medicare will cover lab tests for COVID-19, i.e. beneficiaries pay no out-of-pocket costs; cover an inpatient stay for beneficiaries needing to be quarantined with no additional co-pay if the beneficiary remains in the hospital to be quarantined after an inpatient stay; beneficiaries may also be able to receive Part B prescription refills for more than 30 days, expanded ambulance service, and, Part D will cover COVID-19 approved vaccines when they become available. For beneficiaries with MA coverage, CMS allows these plans to waive cost-sharing for COVID-19 lab tests and MA plans may choose to waive prior authorization requirements related to COVID-19. | See CMS' "Medicare and Coronavirus" website page, here. See also the agency's March 23 memo, "Covid-19 Emergency Declaration, Health Care Providers Fact Sheet," here. | Acute Care Facilities<br>Post-Acute Care Facilities<br>Physicians<br>Insurers |
| Medicare Advantage Telehealth Services Risk Adjustment | CMS sent a letter to inform that Medicare Advantage Organizations and other organizations that submit diagnoses for risk adjusted payment that they are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility | Click here for the letter.<br>• CMS notes that it is important for enrollees in Medicare Advantage to be able to receive clinically appropriate services via telehealth, and CMS appreciates all the necessary steps Medicare Advantage Organizations are taking to help providers and members cope with the pandemic | Acute Care Facilities<br>Post-Acute Care Facilities<br>Physicians<br>Insurers |
| Medicaid Changes | The Families First Coronavirus Response Act, requires nearly all health plans – including Medicaid – to pay for COVID-19 testing, including the lab fees and the fees associated with the doctor's office, urgent care clinic, or emergency room where the test is administered. | For more information go to this Medicaid.gov webpage, "Coronavirus Disease 2019 (COVID-19)," here. | |
| ACA Updates | Concerning the non-group market or individual coverage under the ACA, at least 10 of the 12 states that run their own marketplaces/exchanges are presently offering a special enrollment periods, for most the period ends sometime this month.<br>▪ The 38 states that rely on the federal HealthCare.gov marketplace, it that remains closed. | States with special enrollment periods<br>▪ Rhode Island (enroll by April 15; coverage takes effect 1st of the month following enrollment date) – click here<br>▪ New York (enroll by April 15, on- or off-exchange; coverage takes effect April 1) – click here<br>▪ Nevada (enroll by April 15; April 1 effective date for enrollments completed by April 1, | Acute Care Facilities<br>Post-Acute Care Facilities<br>Physicians<br>Insurers |

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| | | after that plans will take effect May 1) – click here<br>▪ Connecticut (enroll by April 17; coverage takes effect April 1 for people who enroll by April 2; enrollments after April 2 will take effect May 1) – click here<br>▪ Vermont (enroll by April 17; enrollee can choose April 1 or May 1 effective date) – click here<br>▪ Minnesota (enroll by April 21; coverage takes effect April 1) – click here<br>▪ Colorado (enroll by April 30 (extended deadline); coverage takes effect April 1) – click here<br>▪ Washington State (enroll by May 8; coverage takes effect April 1 for people who enroll by April 8; enrollments after April 8 will take effect May 1) – click here<br>▪ Massachusetts (enroll by May 25; enrollments completed by April 23 will have a May 1 effective date; completed by May 23 will have a June 1 effective date, and completed by May 25 will have a July 1 effective date) – click here<br>▪ Maryland (enroll by June 15; enrollments completed by April 15 will have April 1 effective dates) – click here<br>▪ California (enroll by June 30; coverage takes effect the 1st of the month following the enrollment date) – click here<br>▪ District of Columbia (SEP isn't related to COVID-19), but does allow uninsured residents to gain coverage – click here | |
| Uninsured coverage for COVID-19 testing | Families First Coronavirus Response Act, in Sec. 6004<br><br>CARES Act Section 3716<br><br>HHS announced on April 22nd that additional funds from the CARES Act $100 billion could be used to cover the uninsured.<br>• For more on payments for uninsured from this fund, click here. | • COVID-19 testing and related visits must be covered without cost-sharing under the Children's Health Insurance Program (CHIP) and Medicaid during the public health emergency.<br>• State Medicaid programs may also cover COVID-19 testing and related visits for uninsured individuals during this period. The section applies a 100% Federal Medical | |

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| | • HHS opened the portal to begin submitting claims for the uninsured COVID-19 patients, click here.<br>• FAQs for how to utilize the portal, click here.<br>  ○ Please note this fund will consider people covered by short-term plans as insured, which means CARES Act dollars cannot be used to reimburse providers for those individuals' COVID-19 treatment, yet short-term plans will not be viewed as insurance when it comes to COVID-19 testing and thus providers can get federal relief money for enrollees' testing | Assistance Percentage (FMAP) to such coverage.<br>• There was a glitch in the original language however, so in the most recent package, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) a technical amendment was put into place to ensure that this could be followed through in all states – Sec. 3716.<br>• Clarification Regarding Uninsured Individuals, this section would clarify a section of the Families First Coronavirus Response Act of 2020 (Public Law 116-127) by ensuring that uninsured individuals can receive a COVID-19 test and related service with no cost-sharing in any state Medicaid program that elects to offer such enrollment option.<br>• The state will have to take action but this will give them the ability to pay for tests and/or treatment through Medicaid for any uninsured patient that needs testing and/or treatment for COVID-19. | |
| Workforce | | | |
| Staffing | CMS issued an interim final rule on March 30 with a wide range of provisions to make it easier to support existing staff and expand the workforce. Click here for the interim final rule and here for additional details. | ▪ Items include allowing hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, or child care services while the physicians and other staff are at the hospital providing patient care.<br>▪ Local private practice clinicians and their trained staff may be available for temporary employment since nonessential planned medical and surgical services are postponed during the pandemic.<br>▪ Medical residents will have more flexibility to provide services under the direction of the teaching physician and teaching physicians can now also provide supervision virtually using audio/video communication technology.<br>▪ Permit wider use of verbal orders rather than written orders by hospital doctors. | Acute Care Facilities<br>Post-Acute Care Facilities<br>Physicians |

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| | | ▪ Waives the requirements for a nurse to conduct an onsite visit every two weeks for home health and hospice. | |
| Paid Sick Leave and Expanded Family and Medical Leave | ▪ HR 6201, Families First Coronavirus Response Act (FFCRA), includes emergency paid sick days:<br><br>Division D – creates a new federal emergency paid leave benefit program. Applies when:<br>▪ Worker has a current diagnosis of COVID-19.<br>▪ Worker is quarantined to prevent spread of COVID-19.<br>▪ Worker is caring for another person who has COVID-19 or is under quarantine related to COVID-19.<br>▪ Worker is caring for a child or another individual who is unable to care for themselves due to the COVID-19 related closing of school, child care or other care program.<br>Division F<br>▪ Requires all employers to allow employees to gradually accrue 7 days of paid sick leave and to provide an additional 14 days available immediately in the event of any public health emergency.<br>▪ Ensures paid sick leave covers days when a child's school is closed due to a public health emergency, when the employer is closed due to a public health emergency, or if the employee or family member is quarantined or isolated due to a public emergency. | ▪ The department's Wage and Hour Division (WHD) posted a temporary rule issuing regulations pursuant to this new law, effective April 1, 2020.<br>▪ Click here and here for details from the Department of Labor<br>▪ Click here for a Fact Sheet for employers and here for FAQs from the Labor Department.<br>▪ Click here for press release regarding enforcement.<br>▪ Click here for IRS document on tax credits for small and medium size business for leave. | Acute Care Facilities<br>Post-Acute Care Facilities<br>Physicians<br>Insurers |
| Employee Leave | Section 3602 of the CARES Act caps the amount employers would be required to pay per employee for the leave programs:<br>▪ $511 per day, or $5,100 total, for sick leave related to a worker's quarantine or diagnosis.<br>▪<br>▪ $200 per day, or $2,000 total, for sick leave related to caregiving for another quarantined individual or child whose school or day care has closed. | | Acute Care Facilities<br>Post-Acute Care<br>Physicians<br>Insurers |
| Toolkit to Navigate Health Workforce Challenges | HHS released a new toolkit to help state and local healthcare decision makers maximize workforce flexibilities when confronting COVID-19 in their communities. This toolkit includes a full suite of available resources to maximize responsiveness based on state and local needs | The Healthcare Workforce Toolkit is housed on the ASPR Technical Resources, Assistance Center, and Information Exchange (TRACIE). ASPR TRACIE is a healthcare emergency preparedness information gateway that ensures all stakeholders have access to information and resources to improve preparedness, response, recovery, and mitigation efforts including— | |

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| | | • at the federal, state, local, tribal, and territorial government levels;<br>• in nongovernmental organizations; and<br>• in the private sector<br><br>Click here for the Toolkit | |
| Stark Law Waivers | Blanket waivers retroactively effective as of March 1, 2020, allowing payment for claims for designated health services that, but for satisfying conditions of a blanket waiver, would violate the Stark Law.<br><br>The blanket waivers also exempt health care providers from sanctions for noncompliance contemplated by the waivers, absent the government's determination of fraud and abuse.<br><br>In addition to the blanket waivers, requests for individual waivers of sanctions under the physician self-referral law related to COVID-19 will be handled by CMS Baltimore. For more information, click here.<br><br>Click here for OIG Policy Statement. | Click here for the HHS Stark waiver document. HHS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. These include:<br>▪ Hospitals and other providers can pay above or below FMV to rent equipment or receive services from physicians (or vice versa)<br>▪ Health care providers can support each other financially to ensure continuity of care operations.<br>▪ Hospitals can provider benefits to medical staff (meals, laundry, child care) while physicians are at the hospital and engaging in activities that benefit the hospital and patients.<br>▪ Physician-owned hospitals can temporarily increase the number of licensed beds, operating rooms and procedure rooms, even though it would otherwise be prohibited under Stark.<br>▪ Loosens some restrictions when a group practice can furnish medically necessary designated health services in a patient's home.<br>▪ Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis. | Acute Care Facilities<br>Post-Acute Care<br>Physicians<br>Insurers |
| Patient Consent Flexibility | Section 3224 of the CARES Act allows sharing of substance use disorder patient records with broad patient authorization rather than explicit consent each time records are shared. | Click here for SAMSHA guidance on 42 CFR Part 2. | |
| Liability Limits for Volunteers | Section 3215 of the CARES Act limits liability for volunteer health care professionals during the COVID-19 response. | | |

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| Defense Production Act | The president issued an Executive Order (EO) on March 18 evoking the Defense Production Act. Here. On April 2, he authorized the HHS Secretary via memorandum to aid six manufacturers to obtain necessary materials for the equipment. Here | | Hospitals<br>Acute Care Facilities<br>Post-Acute Care<br>Physicians<br>Insurers |
| **Additional Information Technology/Telehealth** | | | |
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| Telehealth | CMS released an interim final rule – it will now pay for an additional 80 services furnished via telehealth including ED visits, Medicare beneficiaries can receive care at home or in a nursing or an assisted living facility, beneficiaries can be qualified for Home Health via telehealth, Home Health can provide services via telehealth and hospice can provide routine home care and clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition.<br>The interim rule fact sheet, here, provides an outline.<br>For a tool kit click here.<br><br>On April 22nd HHS launched a website to provide information about the latest federal efforts to support and promote telehealth services with links to tools and resources for practitioners, click here.<br><br>Avalere Health posted a good resource for providers on telehealth availability, click here.<br><br>Click here for FSMB list of states modifying in-state licensure requirements for telehealth.<br><br>For FAQs on telehealth and HIPAA, click here for info from HHS Office of Civil Rights. | ▪ Payment for more than 80 additional services when furnished via telehealth including emergency department visits, initial nursing facility and discharge visits, and home visits, which must be provided by a clinician that is allowed to provide telehealth. And providers can evaluate beneficiaries who have audio phones only.<br>▪ Telehealth me be used to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.<br>▪ If a physician determines that a Medicare beneficiary should not leave home and the beneficiary needs skilled services, he or she will be considered homebound and qualify for the Medicare Home Health Benefit.<br>▪ Physicians may now utilize virtual Check-In services, or brief check-ins between a patient and provider by audio or video device with both established and new patients.<br>▪ Clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition.<br>▪ Further detail concerning what expanded telehealth services clinicians can provide and related reforms are listed via this March 30 CMS document, “Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19,” here.<br>▪ CMS has stated that facilities do not need to code a call from a provider as a telehealth visit if both patient and provider are within the same building but not in the same room. | Acute Care Facilities<br>Post-Acute Care<br>Physicians<br>Insurers |

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| | | This should be billed as if the provider is in the room.<br>Click here for CMS blanket waivers (updated 4/22/2020) | |
| CMS Rural Health Care and Medicaid Telehealth Flexibilities | CMS released a guidance document on April 2nd, detailing additional opportunities for the utilization of telehealth delivery methods to increase access to Medicaid services in rural health care with an emphasis on substance abuse treatment. | ▪ The document discusses how rural providers can comply with the requirement to publish guidance to states regarding federal reimbursement for furnishing services and treatment for substance use disorders under Medicaid using services delivered via telehealth, including in School-Based Health Centers, click here.<br>Click here for CMS blanket waivers (updated 4/22/2020) | Acute Care Facilities<br>Post-Acute Care<br>Physicians |