Regulatory Round-Up: COVID-19 Legislation

PUBLISHED: APRIL 2020 | AUDIENCE: REVENUE CYCLE

The major provisions of two federal laws—the CARES Act and Families First Coronavirus Response Act—passed in March 2020 that affect revenue cycle operations and reimbursement are summarized below.

CARES Act

The Coronavirus Aid, Relief, and Economic Security Act became law on March 27, 2020. Among other provisions, it expanded unemployment benefits eligibility; temporarily suspended payments and interest accrual on federal student loans; and aimed to prevent and mitigate shortages of drugs, supplies, and healthcare professionals. It builds on the Families First Coronavirus Response Act.

Find the full text of the CARES Act here, and search for the section numbers provided throughout this document for more information on each key takeaway.

Revenue Cycle Key Takeaways

- **Accelerated Medicare Payments**
  - Accelerated or advance Medicare payments are available to Medicare Part A providers and Part B suppliers to alleviate the upfront costs associated with the COVID-19 pandemic and enable healthcare providers to continue delivering high-quality healthcare despite disrupted cash flow.
  - Payments are available to hospitals that have billed Medicare within the past 180 days, are not in bankruptcy, not under medical review or subject to a program integrity investigation, and do not owe Medicare for past overpayments. Requests for accelerated or advance payments must be submitted in writing to the hospital's MAC, and MACs are expected to remit payment (if approved) within seven days of the request. Request forms can vary by MAC and should be obtained directly from the MAC.
  - After receiving an accelerated or advance payment, hospitals should submit claims as normal, and MACS will pay them as normal. After a 120-day grace period, MACs will begin to recoup the accelerated or advance payments from subsequent claims and will continue to do so for the applicable recoupment period based on hospital type (described below). If, at the end of that recoupment period, the MAC has not yet recouped the full accelerated or advance payment, the hospital will owe a lump sum overpayment.
  - **Critical access hospitals**
    - Can request up to 125% of Medicare payments from the previous six months
    - Have a recoupment period of one year
  - **Inpatient acute care hospitals**

    - Can request up to 100% of Medicare payments from the previous six months
    - Have a recoupment period of one year

- **Children's hospitals and certain cancer hospitals**
    - Can request up to 100% of Medicare payments from the previous six months
    - Have a recoupment period of one year

- **Other Part A providers and Part B suppliers**
    - Can request up to 100% of Medicare payments from the previous three months
    - Have a recoupment period of 210 days, with the exception of Part A providers receiving Period Interim Payments, who will undergo recoupment during cost reporting.

- *See Section 3719, Expansion of the Medicare Hospital Accelerated Payment Program During the COVID-19 Public Health Emergency.*

- *A CMS fact sheet also is available here.*

- **Credit Reporting**

- If a healthcare provider relaxes payment plans or other collections activity because the guarantor was affected by COVID-19, credit bureau reporting must be adjusted on those accounts through the end of the window extending 120 days past the termination of the COVID-19 emergency period. If the account was current before the relaxation, it must continue to reflect a current status if the guarantor adheres to the new terms. If the account was delinquent before the relaxation, the status can remain delinquent but can be upgraded to current if the guarantor adheres to the new terms. This does not apply to accounts that have been written off.

- *See Section 4021, Credit Protection During COVID-19.*

- **Diagnostic Test Reimbursement**

- If a payer does not have a contract with a healthcare provider that includes a reimbursement rate applying to COVID-19 diagnostic tests, they must either reimburse the cash price of the test or negotiate a rate with the provider. This builds on the provisions in the Families First Coronavirus Response Act that require all insurers to waive cost-sharing requirements for COVID-19 diagnostic testing (see below).

- *See Section 3201, Coverage of Diagnostic Testing for COVID-19.*

- **DME Reimbursement**

- DME payment adjustments for Medicare beneficiaries were altered slightly. In rural and/or non-contiguous areas, DME payments will be adjusted as normal (sum of 50% of the regional average and 50% of the unadjusted fee schedule), but the end date will be pushed past December 31, 2020, if the COVID-19 emergency period continues at that time. In all other areas, payments will no longer be adjusted to 100% of the regional average. Instead, payments are the sum of 75% of the regional average and 25% of the unadjusted fee schedule as of March 6, 2020, and this methodology will also extend past December 31, 2020, if needed.

- *See Section 3712, Revising Payment Rates for Durable Medical Equipment Under the Medicare Program Through Duration of the Emergency Period.*

- **DRG Add-On Payments**

- Discharges of Medicare beneficiaries can receive a 20% add-on payment to the discharge DRG that applies to the care provided if the patient had a COVID-19 diagnosis. Claims eligible for the add-on generally will have a COVID-19-related diagnosis or condition code.

- *See Section 3710, Medicare Hospital Inpatient Prospective Payment System Add-on Payment for COVID-19 Patients During Emergency Period.*

- **DSH Reductions Delayed**

- Disproportionate Share Hospital payment reductions totaling $12 trillion were scheduled to begin May 23, 2020, and run through fiscal year 2025, but that has been delayed. Reductions will begin December 1, 2020.

- *See Section 3813, Delay of DSH Reductions.*

- **Long-Term Post-Acute Care Reimbursement**

- For the duration of the COVID-19 emergency period, CMS is temporarily waiving the site-neutral payment adjustment for long-term care hospitals. Under that provision, reimbursement was reduced if CMS felt the patient could have been cared for safely in a lower-acuity setting, such as a general acute care hospital, with exceptions for patients who had received care in an ICU before long-term care admission or were on a ventilator for at least 96 hours while admitted at the long-term care facility. CMS also is temporarily waiving the 50% rule, under which long-term care facilities could face further limits on reimbursement if 50% or more of their Medicare discharges fell under the site-neutral provision. These apply to long-term care admissions during the COVID-19 emergency period made "in response to the public health emergency," suggesting the patient might not have a COVID-19 diagnosis but is being admitted to facilitate COVID-19-related treatment to be provided to others elsewhere.

- *See Section 3711, Increasing Access to Post-Acute Care During Emergency Period.*

- **Price Transparency for Testing**

- Healthcare providers administering COVID-19 diagnostic tests must include the cash price for those tests in their price transparency compliance efforts. A maximum fine of $300 daily can be levied for noncompliance.

- *See Section 3202, Pricing of Diagnostic Testing.*

- **Vaccine Coverage**

- When a COVID-19 vaccine becomes available, insured patients will not owe cost-sharing to receive it. This will fall under Part B for traditional Medicare and also applies to commercial insurers, including Part C payers.

- *See Section 3713, Coverage of the COVID-19 Vaccine Under Part B of the Medicare Program Without Any Cost-Sharing, and Section 3203, Rapid Coverage of Preventive Services and Vaccines for Coronavirus.*

Families First Coronavirus Response Act

The Families First Coronavirus Response Act became law on March 18, 2020. Among other provisions, it temporarily creates paid sick leave requirements and expands FMLA eligibility.

Find the full text of the Families First Coronavirus Response Act here, and search for the section numbers provided throughout this document for more information on each key takeaway.

Revenue Cycle Key Takeaways

- **Diagnostic Test Coverage**

- During the COVID-19 emergency period, COVID-19 diagnostic testing must be covered by all health insurers (including Medicare, Medicaid, and other government payers) at no cost to patients, and insurers cannot require pre-authorization or "other medical management requirements" for the tests.

- *See Section 6001, Coverage of Testing for COVID-19.*

- **Medicare Visit Cost-Sharing**

- Medicare beneficiaries (including those with Part C plans) do not owe cost-sharing for the visit necessary for a clinician to evaluate whether they need a COVID-19 diagnostic test if the visit results in an order for that test.

- *See Section 6002, Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19, and Section 6003, Coverage of Testing for COVID-19 at No Cost Sharing Under the Medicare Advantage Program.*

- **Paid Leave**

- **Clinicians are exempt from this requirement.** However, it does not appear the exemption extends to other employees of healthcare systems, including revenue cycle staff, or that it bars employers from providing the additional paid sick leave to clinicians if they choose to do so.

- Private employers with fewer than 500 employees and all public agencies with at least one employee are required to provide paid sick leave equivalent to the employee's average two-week schedule (i.e., 80 hours for full-time staff) if they are under a government quarantine/isolation order, seeking or receiving treatment (including self-isolating at the recommendation of a healthcare provider) for COVID-19, caring for someone who is seeking or receiving treatment for COVID-19, or caring for their child(ren) due to school being closed or other childcare options being unavailable. The legislation indicates exceptions could be made for employers with fewer than 50 employees. There is no minimum employment period required for eligibility.

- The paid leave under this section must be provided before the employee can be required to use other paid time off accruals and is available through December 31, 2020. Employers cannot require the employee to find a replacement worker to cover for them during the leave period.

- If the employee takes the two weeks of paid sick leave because they are under a government quarantine/isolation order, seeking or receiving treatment (including self-isolating at the recommendation of a healthcare provider) for COVID-19, compensation generally must be made at the employee's normal compensation rate. However, compensation in those scenarios is capped at $511 per day and $5,110 cumulative throughout the leave period.

- If the employee takes two weeks of paid sick leave because they are caring for someone who is seeking or receiving treatment for COVID-19 or caring for their child(ren) due to school being closed or other childcare options being unavailable, compensation generally must be at least two-thirds of the employee's normal compensation rate. However, compensation in those scenarios is capped at $200 per day and $2,000 cumulative throughout the leave period.

- *See Division E – Emergency Paid Sick Leave Act.*

- **Unpaid Leave**

  - **Clinicians are exempt from this requirement.** However, it does not appear the exemption extends to other employees of healthcare systems, including revenue cycle staff, or that it bars employers from applying the expanded FMLA terms to clinicians if they choose to do so.

  - FMLA is temporarily expanded to include COVID-19 as a qualifying need, including having to care for children who are unable to attend school or childcare facilities. The expansion is scheduled to last through December 31, 2020.

  - Only the first 10 days of FMLA leave under the COVID-19 expansion can be unpaid if the employee decides not to use any paid time off they have accrued (vacation days). After the first 10 days, employers are required to provide paid leave, paying at least two-thirds of the employee's typical compensation (salary, hourly pay for average hours worked). However, paid leave under the FMLA expansion is capped at $200 per day and $10,000 cumulative throughout the leave period.

  - Two key definitions were altered. First, the expansion applies to employees who have been employed for at least 30 days (previously FMLA required 12 months of employment). Second, the expansion applies to private employers only if they have fewer than 500 employees (FMLA previously applied to private employers with at least 50 employees but no upper limit). The legislation indicates exceptions could be made for employers with fewer than 50 employees.

  - The other provisions of FMLA were not changed, such as the cap of 12 weeks of FMLA leave during a 12-month period.

  - *See Division C – Emergency Family and Medical Leave Expansion Act.*

COVID-19 is an ongoing situation and organizations' processes are changing daily to adapt to various needs during this crisis. As such, this information is up-to-date as of April 2, 2020. HBI is continually monitoring the situation and updating material as we gather additional information. While HBI has attempted to ensure the accuracy of research provided in this document, the information has been obtained from numerous resources. Therefore, HBI cannot guarantee its accuracy and is not liable for any claims or losses that arise from errors or omissions within this document.