Holland & Knight

MEMORANDUM

Date: March 17, 2020

From: Holland & Knight

Re: Coronavirus Response Update

As the country works to combat the spread of Coronavirus Disease 2019 (COVID-19), we will keep clients apprised of the latest developments that could affect patient care and health system operations.

I. Disaster/Emergency Declaration – FEMA

The President issued the Emergency/Disaster Declaration under both the Federal Emergencies Act and the Stafford Act. The Federal Emergency Management Agency (FEMA) indicated that it would proceed to support the lead federal agency (HHS) through its Public Assistance Program. The program provides support to state, local, tribal, and certain private non-profit entities to support emergency response. It is commonly triggered for events such as earthquakes, fires, and hurricanes but is now being used to address an infectious disease emergency. Funding is provided to support emergency protective measures taken at the direction of public health authorities to protect public health and safety. The federal government picks up not less than 75% of the cost.

In this case, the states will enter into an agreement with FEMA that governs the relationship. FEMA provides grant funding and expenditure authorizations, and the local authorities ordinarily manage the response activities. Usually, states stand up their Emergency Operations Centers (EOCs) under their state Emergency Management Agency and requests and authorizations for expenditures flow between FEMA and the State EOC. Non-profit health care providers are very clearly eligible funding recipients under the Public Assistance Program, but they are not entitled to funds per se. We advise keeping records of response expenditures and estimating needs on a going-forward basis.

Resources:

- FEMA Press release may be found here.
- Public Assistance Program Guidance may be found here.

II. Section 1135 Emergency Waivers.

As part of the COVID-19 Emergency Declaration, HHS Secretary Azar has issued a series of blanket Medicare waivers pursuant to Section 1135 of the Social Security Act. Under an ordinary waiver, providers have to request a waiver from the state survey agency or CMS region. Blanket waivers differ in that they apply where all providers in an affected area are believed to be facing similar challenges. It is not necessary to request a waiver. Still, it is a best practice to notify the state survey agency and CMS region that you are implementing them (to avoid reimbursement problems). The blanket waivers cover several issues including the current requirement for a three-day hospital stay before being eligible for SNF coverage; restrictions on housing acute care patients in excluded distinct part units; providers licensure and enrollment requirements; allowing excluded psychiatric patients to be housed in acute

care units; the 25-day average length of stay requirement for LTCHs; appeals deadlines; and rules regarding durable medical equipment replacement and home health.

The Secretary is also accepting Medicaid/CHIP waiver requests from the States. As of this morning, one such request had been approved for the State of Florida providing flexibilities that enable the state to waive prior authorization requirements to remove barriers to needed services, streamline provider enrollment processes to ensure access to care for beneficiaries, allow care to be provided in alternative settings in the event a facility is evacuated to an unlicensed facility, suspend certain nursing home screening requirements to provide necessary administrative relief and extend deadlines for appeals and state fair hearing requests.

Resources:

- Medicare Fee-for-Service (FFS) response to the public health emergency on the Coronavirus. Although Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act) on March 13, 2020, ***they are retroactive to March 1, 2020.***
- Secretary Azar exercises authority to waive sanctions and penalties against covered hospitals that do not comply with certain provisions of the HIPAA Privacy Rule.
- For general background on 1135 waivers, visit here.

III. Public Health Funding.

The initial Coronavirus Emergency Supplemental Appropriation Act provided $8.3 billion in response funding mainly focused on funding activities under the Pandemic and All-Hazards Preparedness Act and related public health response. This included NIH vaccine research; countermeasures development; acquisition of personal protective equipment, drugs, and other supplies; Centers for Disease Control funds for testing, surveillance, and other response activities (including support for state, territorial, and some local public health departments. Also included is approximately $200 million for the Hospital Preparedness Program, which provides direct support to hospitals or regional partnerships. This is roughly the same amount that was provided six years ago in the Ebola emergency appropriation bill that was used to stand up the State and Regional Ebola and Special Pathogen Treatment Centers and a network of about 200 Ebola assessment hospitals. We anticipate a likelihood of more HPP funding being made available in subsequent legislation.

Resources:

- The bill text may be found here and a summary here.

IV. Telehealth Coverage Policies.

On March 5, Congress passed the *Coronavirus Supplemental Appropriations Act,* which included a $500 million authorization to enhance telehealth services. The legislation gives the U.S. Department of Health and Human Services (HHS) Secretary the authority to waive or modify certain telehealth Medicare requirements when the President has declared a National Emergency, or the HHS Secretary has declared a Public Health Emergency.

Specifically, the legislation gives the HHS secretary the authority to waive the originating site requirement for telehealth services provided by a qualified provider to Medicare beneficiaries. The waiver extends the use of telehealth services in two distinct ways: (1) the originating site (where the

patient is located at the time of service) does not have to be in a rural Health Professional Shortage Area (HPSA); and (2) the list of approved originating sites has been expanded to include the patient's place of residence (that is, home).

The legislation also allows telehealth services to be provided to Medicare beneficiaries by phone, but only if the phone allows for audio-video interaction between the qualified provider and the beneficiary.

This expansion is limited to qualified providers who have furnished Medicare services to the individual in the three years prior to the telehealth service (or another qualified provider under the same tax identification number that has provided services within three years). The patient must initiate the service and give consent to be treated virtually, and the consent must be documented in the medical record before initiation of the service.

On March 16, the House of Representatives passed a technical correction to H.R. 6201, the "Families First Coronavirus Response Act." It now moves to the Senate. It includes a fix to the initial telehealth language regarding people age 65 that do not have an existing Medicare billing relationship. The legislation passed on March 5 was implemented in a way that makes the provider's prior relationship with the patient a Medicare relationship. If a 65-year-old patient had commercial insurance and visited their primary care doctor, the visit wouldn't count toward the previous relationship requirement because it wasn't covered by Medicare.

On March 17, CMS released more details on the waiver. Most notably, CMS is not enforcing requirements that an existing patient-provider relationship exists for Medicare telehealth services. The established patient provision would still apply to e-visits and virtual check-in. CMS is also not limiting the waiver to those with a COVID-19 diagnosis.

Regarding Medicaid telehealth services, A Medicaid FAQ was issued stating that state Medicaid programs have broad authority to utilize telehealth within their Medicaid programs, including telehealth or telephonic consultations in place of typical face-to-face requirements when certain conditions are met.

Resources:

- CMS has released FAQs outlining the new Medicare telehealth waiver.
- OCR releases notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency.
- CMS released Medicaid fee-for-service telehealth guidance.

V. Second Legislative Relief Package

As mentioned above, H.R. 6201 re-passed the House today with some changes from the prior version. It has been agreed to by the House and Treasury Secretary Mnuchin. As of this writing, the Senate may approve the bill and send it to the White House or fold it into a broader package now under discussion (see below). The bill is primarily concerned with non-health care issues such as unemployment insurance, sick leave, and family leave, and addressing anticipated nutrition access problems through substantial funding (and flexibility) for WIC, SNAP and the National School Lunch Program. However, it also includes a $1 billion appropriation to the National Disaster Medical System to cover COVID-related diagnostic testing of uninsured persons. There are also a series of other provisions eliminating

commercial insurance cost-sharing for testing, waiving Medicare cost-sharing for testing, requiring coverage of testing under Medicaid and CHIP with no cost-sharing and 100% FMAP, and creating a state option to cover testing for uninsured persons.

Finally, the legislation includes a 6.2% increase in Medicaid FMAP for any quarter that falls within the aforementioned public health emergency declaration. States may not receive this enhanced Medicaid match if they impose more restrictive eligibility, increase requirements for local contributions to the state share, or increase provider contributions to the state share.

VI. Economic Response Legislation.

The House of Representatives is on recess, and it is unclear when they will return. The Senate is in session and is currently taking the lead on crafting a large tax/spending/regulatory relief bill to address the massive impacts of the COVID-19 outbreak on the U.S. economy. Similar to the 2009 American Recovery and Reinvestment Act (aka "Stimulus bill"), the price tag is anticipated to be in the neighborhood of $1 trillion. At this time the parameters of a bill are fluid, but can be expected to include tax or guaranteed loan relief for industries severely impacted by the outbreak (e.g., airlines); broader relief for the negative impact on businesses of all manner; relief for individuals and families (e.g., refundable tax credits generating direct payments); relief for state and local governments; and stimulus spending.

Beyond requests for top-of-mind issues such as coverage of unanticipated response costs, and solutions to the testing and PPE log jams, health care stakeholders are recommending a number of responsive actions. These include Medicare sequestration relief, enhanced Medicaid funding, funding for treatment or quarantine facilities, and general economic relief.