



OREGON'S SENATOR JEFF MERKLEY

Coronavirus Resources: Medicare

Sen. Merkley, using his leadership position on the Senate Appropriations Committee, fought hard to make sure the \$2.2 trillion coronavirus relief funding stabilizes families, workers, small businesses, housing, education, agriculture, and health care. As these resources are distributed, Sen. Merkley's office will keep Oregonians up to date on what in the bill helps individuals and communities, and how to access the resources. He will continue to fight to make sure much-needed aid gets to the people who need it most.

Coronavirus relief to help strengthen Medicare services:

This bill provides key resources and new flexibility to help strengthen Medicare services during the coronavirus crisis. Here are answers to some of the common questions about how Medicare will be affected by this legislation.

How does this bill increase access to telehealth services for seniors and other Medicare beneficiaries?

The *CARES Act* gives the Secretary of Health and Human Services (HHS) broad authority to allow more health care providers to provide telehealth services to Medicare beneficiaries, including in the beneficiaries' homes to avoid potential exposure to COVID-19, and provide more flexibility in terms of how those telehealth services can be provided. The HHS Secretary must put out guidance explaining how this expanded waiver authority will be used to increase access to telehealth services for seniors and other Medicare beneficiaries.

I've heard from Federally Qualified Health Centers (FQHCs) including Community Health Centers (CHCs) and Rural Health Clinics (RHCs) that the Administration won't allow them to use telehealth and get paid. Does this bill help those providers deliver care via telehealth?

Yes. The *CARES Act* requires the HHS Secretary to provide Medicare payment to FQHCs (including CHCs) and RHCs for telehealth services provided to seniors and other Medicare beneficiaries, including in the beneficiaries' homes to avoid potential exposure to COVID-19, during the COVID-19 public health emergency. Medicare would be required to pay the FQHC or RHC at rates similar to those for telehealth services provided from a doctor's office. Costs associated with those telehealth services would not affect the prospective payment system for FQHCs or the all-inclusive rates for RHCs.

How does this bill help clinical laboratories when it comes to Medicare?

The *CARES Act* prevents scheduled Medicare payment cuts for clinical diagnostic laboratory tests furnished to Medicare beneficiaries in 2021. It also delays by one year—until 2022—the upcoming reporting period during which laboratories are required to report private payer data.

How much will patients have to pay for the COVID-19 vaccine once it becomes available?

The *CARES Act* ensures that the vaccine itself and its administration is free to beneficiaries with Medicare Part B and those with Medicare Advantage who receive the vaccine from an in-network provider.

How will seniors access the medications they need while also being told it's better to stay at home? In the past, Medicare drug plans only let beneficiaries receive a 30 day supply of their prescription.

Under the *CARES Act*, during the COVID-19 Public Health Emergency (PHE), a senior on Medicare can get up to 90 days of a prescription if that is what the doctor prescribed, as long as there are no safety concerns. Medicare drug plans will also allow beneficiaries to fill prescription early for refills up to 90 days, depending on the prescription.

Hospitals are facing cash flow challenges due to canceling elective services. Is there anything in this bill to help hospitals stay afloat, even temporarily?

The COVID-19 emergency has created significant cash flow concerns for many hospitals. Hospitals need reliable and stable cash flow to help them maintain and support their workforce, buy essential supplies, create additional infrastructure, and keep their doors open to care for patients. During the COVID-19 public health emergency (PHE), the *CARES Act* creates the opportunity for hospitals to receive accelerated payments. Specifically, acute care hospitals, critical access hospitals (CAHs), children's hospitals, and prospective payment system-exempt cancer hospitals (PCHs) will be able to request accelerated Medicare payments for inpatient hospital services. This is an expanded set of hospitals compared with the existing accelerated payment program.

Rather than waiting until claims have been processed to issue payment, Medicare will work with qualified and interested hospitals to estimate their upcoming payments and give that money to the hospital in advance. Qualified facilities can request a lump sum or periodic payment reflecting up to six months of Medicare services. Accelerated payments must be repaid to Medicare, however a qualifying hospital would not be required to start paying Medicare back for four months after receiving the first payment. Hospitals would have at least 12 months to complete repayment without paying interest.

Hospitals interested in receiving accelerated payments should contact their Medicare Administrative Contractor (MAC). To learn which MAC to contact, please look [here](#).

Does the bill give additional flexibility for hospice providers?

Yes. In order for a qualified beneficiary to receive hospice benefits, a hospice physician or nurse practitioner must certify their eligibility. Typically, a recertification must be done in person. The *CARES Act* allows hospice physicians and nurse practitioners to conduct these visits via telehealth for the duration of the PHE.

Many hospitals are concerned that there aren't enough ICU beds to take care of those with COVID-19, and inpatient rehabilitation hospitals (IRF) and long-term care hospitals (LTCH) are trying to help build capacity. However, current rules and regulations won't allow them to take certain patients. What does the CARES Act do to help?

The *CARES Act* makes changes to both IRFs and LTCHs to provide hospitals with more flexibility when discharging patients in order to maximize bed capacity. It also opens up existing beds at IRFs and LTCHs to increase the availability of post-acute services.

Currently, in order to be admitted to an IRF, Medicare patients must be expected to participate in at least three hours of intensive rehabilitation at least five days per week (also known as the “three-hour rule”). The *CARES Act* waives this requirement so that IRFs have the ability to accept more patients who may otherwise be sent to other post-acute facilities, such as nursing homes.

Patients who are admitted to LTCHs usually must meet certain clinical criteria for an LTCH to receive a higher Medicare payment. If less than half of an LTCH’s patients meet these criteria, they are no longer eligible to receive any LTCH payments. The *CARES Act* waives both of these policies for the duration of the PHE so that LTCHs may accept as many patients as necessary at their LTCH rate, without regard to the clinical criteria. By waiving these criteria, an LTCH will be able to take more patients from an acute care hospital and still get paid.

With more patients needing to stay at home, and a growing concern over health care workforce shortages due to COVID-19, how does the CARES Act help those who depend on the home health benefit?

Under current law, only physicians are able to certify the need for home health services. The *CARES Act* makes a permanent, statutory change to allow physician assistants, nurse practitioners, and clinical nurse specialists to order home health services for beneficiaries, reducing delays and increasing beneficiary access to care in the safety of their home.

The *CARES Act* also directs the Secretary of Health and Human Services (HHS) to encourage the use of telecommunications systems, including remote patient monitoring, to deliver home health services consistent with the beneficiary care plan during the COVID-19 emergency period. This allows patients to receive certain home health services without a provider entering their home.

Treating patients with COVID-19 is very resource intensive for hospitals. How will Medicare ensure that hospitals are adequately reimbursed for treating COVID-19 patients?

The *CARES Act* increases Medicare reimbursement to care for a COVID-19 patient by 20 percent (specifically, the Act increases the weighting factor of DRGs for inpatients diagnosed with COVID-19 by 20 percent). This add-on payment for inpatient hospital services recognizes the increased costs incurred by providers and will be applied for the duration of the COVID-19 emergency.

If a hospital has not treated any cases of COVID-19, are there other ways it can benefit from the Medicare policies in the bill?

Yes. The *CARES Act* temporarily lifts the Medicare sequester, effectively adding an additional two percent for services provided from May 1 through December 31, 2020. This will boost payments for hospital, physician, nursing home, home health, and other care, giving prompt economic assistance to health care providers that treat Medicare patients.

If a patient has COVID-19 and has to enter the hospital, can their regular personal care attendant, who they depend on at home, still help while the patient is in the hospital?

Under the *CARES Act*, state Medicaid programs now have the ability, should they choose to use the option, to allow direct support professionals to continue to provide care and services for patients they are supporting in the hospital, including seniors and individuals with disabilities.

For updates: Visit merkleysenate.gov/coronavirus for updates on these and other resources as the relief bills are implemented.