



MEMORANDUM

November 6, 2020

TO: Tribal Health Clients
FROM: Hobbs, Straus, Dean & Walker, LLP
RE: CMS Publishes Final Rule Establishing Payment for COVID-19 Testing and Vaccination under Medicare and Private Insurance and other issues

Today, the Center for Medicare and Medicaid Services published an Interim Final Rule with Request for Comments that sets out new rules for COVID-19 testing and treatment and implements other provisions of the Families First Coronavirus Response Act and the CARES Act, (CMS-9912-IFC). 85 Fed. Reg. 71142 (Nov. 6, 2020). The Interim Final Rule addresses a number of issues, including:

- Setting out payment for COVID-19 vaccine and administration under Medicare Part B;
- Setting out rules for Medicaid and CHIP reimbursement of COVID-19 vaccine and administration with no cost sharing;
- Requiring providers to publish the cash price for COVID-19 testing and establishing civil monetary penalties for providers who do not comply with the new requirements;
- Requiring group health plans to pay for COVID-19 testing and vaccination with no cost sharing within 15 days of the vaccine being made available;
- Establishing an add-on payment under Medicare for new COVID-19 treatments like Remdesivir;
- Providing additional flexibilities to States to reduce Medicaid benefits while still receiving additional FMAP reimbursement during the public health emergency;
- Extending the reporting period for the Comprehensive Care for Joint Replacement (CJR) model;
- Giving states additional flexibilities to reduce public notice and tribal consultation in approving Section 1332 waivers during the public health emergency.

The Interim Final Rule with opportunity for comment (IFC) goes into effect immediately, although the agency is taking comment on it after publication. We provide a brief summary of each provision and its impact on Indian Health Care Providers. One issue to pay particular attention to is the requirement that all providers, including tribal providers, to publish COVID-19 testing charges on their websites and the potential impact that will have on negotiating reimbursement rates from group health plans (i.e., private insurance).

We discuss that in more detail below. As always, if you have any questions or would like any more information about these new rules, please do not hesitate to contact us.

1. New Medicare Part B Reimbursement Rates for COVID-19 Vaccine and Administration

The IFC provides that Medicare Part B will pay for COVID-19 vaccine and its administration under separate codes. It provides that Medicare Part B will pay for 100 percent of the cost of the vaccine and provides that it will not count towards Medicare Part B deductibles. The cost of the vaccine will be reimbursed at 95 percent of the Average Wholesale Price. The IFC also provides that Medicare Advantage plans must also cover the cost and administration of COVID-19 vaccine at no cost. The rules provide that because the cost of COVID-19 administration was not taken into account in making capitation payments to Medicare Advantage plans, reimbursement for COVID-19 will continue to be made using fee for service until those costs are accounted for. The rule also establishes that COVID-19 vaccination will be provided with no cost sharing by out of network providers.

2. Medicaid and CHIP Coverage of COVID-19 Vaccine with no cost sharing

Section 6008 of the FFCRA provided states with an additional 6.2 percent in Medicaid Federal Matching Assistance Percentage (FMAP) during the public health emergency, but States are required to cover COVID-19 vaccine and administration at no cost in order to receive the additional match. CMS stated that all states have elected to receive this funding, so that it expects all State plans to cover COVID-19 vaccine and administration at no cost sharing. The IFC provides that States must cover the cost of administration of the vaccine, even if the vaccine is provided at no cost, such as from federal sources of supply. The IFC states that the Centers for Disease Control will determine at a future date whether to include COVID-19 vaccine in the vaccine for children program. The rule points out that while Section 6008 does not apply to CHIP, those plans are already required to cover all ACIP recommended vaccines with no cost sharing already.

The IFC states that after the public health emergency ends, States may continue to cover COVID-19 vaccine and administration, but can impose cost sharing. The IFC confirms, however, that American Indians and Alaska Natives would be exempt from that cost sharing.

The IFC does not make any changes to rates or reimbursement rules for AI/ANs. As a result, we expect that State plans will reimburse Indian health care providers for COVID-19 vaccine and administration at the rates set out in the State plan, which is generally the IHS OMB rates.

3. Requirement for Providers to Publish Cash Price of COVID-19 Tests

Section 6001 of the FFCRA, as amended by the CARES Act, requires group health plans (private insurance) and issuers to reimburse providers of COVID-19 diagnostic tests at the negotiated rate. In the absence of a negotiated rate, the plan or issuer may reimburse the provider at an amount equal to the cash price of the rate the provider has listed on its website or a rate lower than the cash price as negotiated by the plan or issuer.

Section 3202(a) of the CARES Act requires providers of diagnostic tests to publish the cash price of the test. The IFC sets out a new set of regulations at 45 C.F.R. Part 182, “Price Transparency for COVID–19 Diagnostic Tests.” This new requirement applies to all providers, including Indian health care providers. It requires them to publish the “cash price” of COVID-19 tests on their website. In order to ensure that price can be readily found by web search engines, the rules require that all of the following terms be included on the provider’s homepage: the provider’s name; “price”; “cost”; “test”; “COVID”; and “coronavirus.” There is an exception for providers who do not have websites, but they must still publish and provide the cash price. Failure to comply with these requirements will result in civil monetary penalties.

These two requirements may pose difficulty for Indian health care providers, particularly those who do not serve non-IHS beneficiaries. Indian health care providers generally do not charge the IHS beneficiaries they serve anything. As a result, the cash price for testing will be zero.

This creates an issue, however, for Indian health care providers trying to get reimbursed from group health plans. If an Indian health care provider does not have a negotiated rate with an insurance plan, the default rate is the cash price published on the website. If the cash price for IHS beneficiaries is zero, health insurance providers may take the position that the reimbursement they have to pay is zero.

We believe that Indian health care providers should be able to address this issue by listing the cash price for individuals with no form of coverage as zero, and then establish a cash price for individuals with insurance coverage. The IFC states that:

"We do not believe that posting a “cash price” should prevent a provider of a diagnostic test for COVID-19 from offering testing for free to individuals as charity care or in an effort to combat the public health crisis, rather, the “cash price” would be the maximum charge that may apply to a self-paying individual paying out-of-pocket."

However, we would like to confirm this with CMS. We will be working through the TTAG to do so.

4. Requirement for Group Health Plans to pay for COVID-19 testing with no cost sharing

The IFC confirms that Section 2713 of the Public Health Service Act requires group health plans to cover the cost of administration of immunization with no cost sharing, regardless of whether a provider is in-network or not. The IFC also provides that group health plans must begin providing coverage of COVID-19 vaccines within 15 days of their being made available, but only during the public health emergency.

5. Add on payment for certain COVID-19 treatments

The IFC establishes a new add on payment through the Inpatient Prospective Payment System for new COVID-19 treatments. The IFC creates a new COVID-19 Treatments Add-On Payment under the IPPS for two new treatments: Remdesivir and COVID-19 convalescent plasma. The rule may include others as they become available. Please let us know if you would like more information about this new add on payment.

6. Flexibility for States to Reduce Medicaid Benefits

As discussed above, Section 6008 of FFCRA provides States with an additional 6.2 percent federal match during the public health emergency. One of the conditions for receipt of these funds is that States not reduce eligibility or benefits. This is called a maintenance of effort (MOE) requirement. States have been resistant to this requirement, particularly as their economies take a hit during the pandemic.

The IFC implements a new set of rules that gives States more flexibility to reduce benefits during the pandemic. It would allow States to move beneficiaries from one group to a different group with a more limited set of services, limited visits and increased copays. The rule creates three tiers of services: services that provide minimum essential coverage; services that do not provide minimum essential coverage but do cover COVID-19 testing and treatment, and services that do not provide minimum essential coverage and do not cover testing and treatment. The rule allows States to move individuals to groups that have less coverage or increased cost-sharing, so long as they are in the same tier. We note that the rule that AI/ANs are not charged any cost-sharing is still in effect and would exempt AI/AN from any cost sharing regardless of this new flexibility. However, AI/AN would not be exempt from being moved to a group with fewer benefits covered.

7. Extending Comprehensive Care for Joint Replacement

CMS has created a new pilot program creating new payments for joint replacement under its Comprehensive Care for Joint Replacement. The program had certain deadlines that CMS is extending due to the COVID-19 pandemic. We are not aware of any tribal program participating in this program, but please let us know if you would like more information about this.

8. Providing States Flexibility to Provide Less Consultation on Section 1332 waivers.

Section 1332 of the Affordable Care Act allows States to apply for a waiver of certain marketplace rules so long as the waiver provides equivalent coverage. The IFC provides states with additional flexibility to curtail notice and comment, including tribal consultation, for Section 1332 waivers both before they are submitted to CMS and after they are approved.

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If you have any questions or would like further information on the topics raised in this announcement, please contact Elliott Milhollin (emilhollin@hobbsstrauss.com or 202-822-8282); Geoff Strommer (gstrommer@hobbsstrauss.com or 503-242-1745).