PUBLICATION

A Deeper Dive into Telehealth, Graduate Medical Education and Rural Health Care Provisions in the Stimulus Legislation

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In addition to the key health care provisions included in the Consolidated Appropriations Act of 2021 (Stimulus Legislation) summarized in Baker Donelson's recent publication, the new legislation includes a few additional provisions related to telehealth, graduate medical education (GME) payments, and rural emergency hospitals that we want to highlight in further detail. Notably, the Stimulus Legislation will expand Medicare payment for mental health services furnished via telehealth in urban areas and to beneficiaries in their homes. Additionally, the legislation includes provisions to increase Medicare GME payments and amend legislative language that has caused new teaching hospitals to inadvertently create extremely low permanent GME payment limits based upon hosting resident rotators. The legislation also establishes Medicare payment for rural emergency hospitals as a new category of provider that may enroll in certain rural areas to provide emergency department, observation, and outpatient services at an enhanced payment rate.

Telehealth

Expansion of Payment for Mental Health Services Furnished via Telehealth

The Stimulus Legislation expands Medicare payment for certain mental health services furnished through telehealth by eliminating statutory geographic originating site requirements for these services even after the COVID-19 public health emergency (PHE) terminates. Specifically, the legislation authorizes Medicare payment for telehealth services provided for purposes of diagnosis, evaluation or treatment of a mental health disorder even if patients are in urban areas or their homes. Medicare payment will continue to be available after the waivers tied to the COVID-19 PHE are lifted at the termination of the PHE for these mental health telehealth services as long as the patient has received an in-person item or service reimbursable by Medicare from the physician or practitioner within six months prior to receiving the telehealth service.

Addition of "Rural Emergency Hospitals" to the list of Telehealth Originating Sites

The legislation expands the list of sites where a Medicare beneficiary may be located when receiving telehealth services in order to be eligible for Medicare payment. Outside of the COVID-19 PHE (during which Congress has temporarily waived statutory Medicare telehealth payment requirements), Section 1834(m) of the Social Security Act (42 USCA § 1395m(m)) limits Medicare payment for telehealth services to certain originating sites. These sites are described in the statute and include physicians' offices, critical access hospitals (CAHs), rural health clinics (RHCs), federally qualified health centers (FQHCs), hospitals, hospital- or CAH-based renal dialysis centers, skilled nursing facilities (SNFs), community mental health centers (CMHCs), certain renal dialysis facilities and the home of an individual (but only for ESRD home dialysis services, telehealth services furnished for the treatment of substance use disorders and the mental health services furnished by telehealth as newly added and explained in the paragraph above). The Stimulus Legislation adds rural emergency hospitals (which were newly established by the legislation as a Medicare provider designation, as explained in further detail below) to the list of sites where a beneficiary may be located when receiving telehealth services that are eligible for Medicare payment.

FCC COVID-19 Telehealth Program – New Metrics and Application Review Process for Additional $249.95 Million in Funding

As noted in Baker Donelson's prior article, the Stimulus Legislation includes an additional $249.95 million in funding for the Federal Communications Commission (FCC) COVID-19 Telehealth Program. As required by the legislation, the FCC Wireline Competition Bureau (Bureau) issued a Public Notice on January 6, 2021, which will be published in the Federal Register. The Bureau is seeking comments on the following:

- The metrics it should use to evaluate applications for the new funding (e.g., Should providers serving a large percentage of COVID-19 patients be prioritized? Are there specific types of telehealth and connected care services that should be prioritized?);
- How to treat applications filed during the rounds for awards using the funding appropriated under the CARES Act;
- Whether to continue to target funding to the hardest hit areas, and if so, how to define these areas;
- Whether to maintain the Round 1 goal of not awarding more than $1 million per applicant, and whether this should apply to statewide entities or large health care providers and systems;
- Whether applicants should be required to demonstrate the eligibility of the services and connected devices for which they seek funding on their applications during Round 2; alternatively, what documentation or demonstration should be required to show that the applicant will use the funding requested for services and devices eligible for support; and
- Any additional improvements that could be made to the application, review, and invoicing process beyond those proposed based on lessons learned during Round 1.

The legislation requires that at least one applicant should receive the funding from the program in each state and the District of Columbia, unless there is no eligible applicant. To fulfill this nationwide distribution requirement, the Bureau proposes establishing an application filing window for Round 2 applications rather than accepting applications on a rolling basis. The Bureau seeks comments on this approach, and if adopted, how long the window should be open. After the comment period ends, and at least 15 days before the FCC first commits the Stimulus Legislation funds, the FCC must provide to the appropriate congressional committees notice of the metrics it plans to use to evaluate new applications.

Additionally, the FCC will allow applicants who applied for Round 1 Program awards under CARES Act funding to update or amend their applications taking into account the new metrics for the new Stimulus Legislation funding. The Bureau proposes that any Round 1 applications that are not resubmitted will not be considered for Round 2 and seeks comments on other aspects of how to prioritize Round 1 applicants who resubmit versus applicants that apply for the first time for Round 2. Comments on all of the above, as well as other proposals and questions raised in the Public Notice, are due on or before January 19, 2021.

Graduate Medical Education Payments

Distribution of Additional GME FTE Cap Slots

The legislation includes provisions to fund and distribute an additional 1,000 full-time equivalent (FTE) GME residency cap slots (GME Cap Slots). The new GME Cap Slots will be made available for fiscal year 2023 and each succeeding fiscal year until the aggregate number of slots are distributed to hospitals that apply for the slots subject to a new distribution process outlined in the statute. Up to 200 GME Cap Slots will be awarded each fiscal year. Hospitals that apply for the slots will be notified of the results of each application process by January 31st of the year that the cap increase will apply. The cap increase will take effect July 1st of that year.

When distributing the new GME Cap Slots, the following must be considered:

- The demonstrated likelihood of the hospital filling the new positions within the first five training years beginning after the date that the increase would be effective.
- At least ten percent of the aggregate number of slots must be distributed to each of the following categories of hospitals:

  - Hospitals located in a rural area or an area outside a Metropolitan Statistical Area;
  - Hospitals training over their GME FTE caps for the most recent cost report that is settled or under audit as of the date of enactment of the Stimulus Legislation;
  - Hospitals in states with –
    - new medical schools that received "Candidate School" status from the Liaison Committee on Medical Education (LCME) or that received "Pre-Accreditation Status" from the American Osteopathic Association Commission on Osteopathic College Accreditation on or after January 1, 2000 (AOA Commission on Osteopathic College Accreditation), and that have achieved or continue to progress toward "Full Accreditation Status" (as defined by the LCME) or toward "Accreditation Status" (as defined by the AOA Commission on Osteopathic College Accreditation).
    - Additional locations and branch campuses established on or after January 1, 2000, by medical schools with "Full Accreditation Status" or "Accreditation Status" as defined above.
  - Hospitals that serve as designated health professional shortage areas (HPSAs) under Section 332 (a)(1)A) of the Public Health Services Act.

Hospitals may not be awarded more than 25 additional FTE cap slots through the distribution. Additionally, hospitals may not receive a cap increase through the new distribution unless the hospital agrees to increase the total number of FTE residency positions under its approved medical residency training program by the number of FTE cap slots awarded.

With respect to the additional FTE caps slots awarded through this new distribution, the per resident amount (PRA) used to determine direct graduate medical education (DGME) payments will be determined based on the PRA for primary care and nonprimary care as previously computed for that hospital.

Hospitals may enter GME affiliation agreements with newly awarded FTE cap slots beginning the fifth year after the effective date of any cap increase they receive through the new distribution.

Establishment of Per Resident Amounts and GME Caps for Hospitals that Hosted Resident Rotators

The Stimulus Legislation includes provisions to prevent hospitals without teaching programs that have previously hosted rotators without a GME affiliation agreement from inadvertently triggering the establishment of extremely low PRAs (which are used to establish DGME payments). Under the legislation, new teaching hospitals that have not entered a GME affiliation agreement would not trigger their PRAs until the hospital has trained at least 1.0 FTE resident in an approved medical residency training program in a cost reporting period. Any hospital that (a) already established a PRA of less than 1.0 FTE in a cost reporting period beginning before October 1, 1997, or (b) up to 3.0 FTEs for any cost reporting period between October 1, 1997 and the date of enactment of the legislation, will be able to establish a new PRA. This new PRA could be established for hospitals in category (a) that report training at least 1.0 FTE, or for hospitals in category (b) that report more than 3.0 FTEs in a cost reporting period within five years of enactment of the Stimulus Legislation.

In a similar manner, the Stimulus Legislation also prevents new teaching hospitals from triggering low GME FTE caps by hosting resident rotators from new programs. In the future, new teaching hospitals will no longer be able to establish GME FTE caps until they have trained 1.0 FTEs. Additionally, hospitals will be able to establish new FTE caps if they previously established a base year cap below 1.0 FTE before October 1, 1997,

or a cap based on training no more than 3.0 FTEs from a new residency program between October 1, 1997 and the date of enactment of the legislation.

The longstanding rules for determining PRAs and FTE caps will be applied to adjust the PRAs and FTE caps of hospitals that increase their PRAs or FTE caps under this provision based on FTEs reported in the five-year period after enactment.

Increasing GME Caps for Urban and Rural Hospitals Participating in Rural Training

For cost reporting periods beginning on or after October 1, 2022, the legislation directs HHS to establish new rules to allow urban hospitals to create rural training track programs with rural hospitals without obtaining separate accreditation for these programs. Under the new rules, CMS will adjust the FTE caps of urban hospitals that previously established a medical residency program or rural tracks in a rural area, or in the future, establish an accredited program where 50 percent of the training occurs in the rural area. Removing the confusing requirement to separately accredit programs with significant rural training as rural training track programs will make it easier for urban hospitals to support rural training and expand their FTE caps by establishing residency training programs where at least half their residency training occurs in a rural area.

Rural Emergency Hospitals

The legislation establishes Medicare payment for "rural emergency hospitals" as a new provider designation. Pursuant to the statutory language, a "rural emergency hospital" will be defined as a facility that:

- Provides emergency department services, observation care, and certain outpatient, medical and health services, but does not provide any acute care inpatient services;
- Satisfies Medicare requirements of having a staffed emergency department 24 hours a day, 7 days a week.;
- Has a physician, nurse practitioner, clinical nurse specialist, or physician assistant available to furnish rural emergency hospital services in the facility 24 hours a day;
- Has a transfer agreement with a level I or level II trauma center; and
- Is located in a state that provides for licensing rural emergency hospitals under state or applicable local law, and is licensed pursuant to such law.

The facility must enroll as a rural emergency hospital and demonstrate that it can satisfy these requirements. Rural emergency hospitals will be subject to EMTALA requirements and must post the required signage informing patients of EMTALA rights, as well as information on participation in the Medicaid program under a state plan. Additionally, rural emergency hospitals must satisfy conditions of participation applicable to critical access hospitals (CAHs) with respect to emergency services and hospital emergency departments. Further determinations on the specifics of the conditions of participation that will apply will be determined by HHS through implementing regulations. A rural emergency hospital may include a distinct part unit (DPU) of a facility licensed as a skilled nursing facility (SNF) as long as the DPU meets SNF regulatory requirements.

Rural emergency hospitals will be paid for services furnished on or after January 1, 2023, at an enhanced Outpatient Prospective Payment System (OPPS) rate for covered outpatient services increased by 5 percent to reflect higher costs incurred by these hospitals. Copayment amounts paid by beneficiaries will not reflect the 5 percent add-on to the OPPS payment rate. Rural emergency hospitals will also receive an additional facility payment on a monthly basis, which will be determined by CMS through regulation. This monthly payment is required to be 1/12 of a Medicare subsidy amount that will be determined for 2023 as an amount equal to:

- The excess (if any) of the total amount paid by Medicare to all CAHS in 2019, over the estimated total amount HHS determines would have been paid by Medicare in 2019 if payment were made for

inpatient hospital, outpatient hospital, and SNF services under the applicable PPS for such services during the year, divided by

- The total number of CAHs in 2019.

A facility is eligible to convert to a rural emergency hospital if, as of the date of enactment of the legislation, it was designated as a CAH, or as a subsection (d) hospital that has (a) 50 or fewer beds and (b) is located in a county in a rural area (i.e., area outside an OMB-defined, Metropolitan Statistical Area) or has reclassified as rural for IPPS payments pursuant to 42 CFR § 412.103. When submitting an application for enrollment, the facility must include an action plan for initiating rural emergency services with a detailed transition plan that lists the specific services the facility will retain, modify, add and discontinue. This should include a description of the services that the facility intends to furnish on an outpatient basis and a description of Medicare covered services that the facility will support with enhanced payments, which could include telehealth services and ambulance services. After converting and enrolling as a rural emergency hospital, facilities may elect to convert back to a CAH or subsection (d) hospital, if they satisfy applicable requirements for such designations.

Quality measurement reporting requirements, which may include claims-based outcomes measures or surveys of patient experience, will be established through implementing regulations. These data will have to be submitted by rural emergency hospitals beginning in 2023, or one year after the date reporting measures are specified through regulation. When specifying performance measures, HHS will consider ways to account for the fact that rural emergency hospitals lack sufficient case volume to ensure that performance rates for such measures are reliable. Procedures will be established to make the quality reporting data available to the public.

Takeaways

In sum, the Stimulus Legislation includes several long-awaited amendments to existing statutory limitations on Medicare telehealth and GME payments, and also makes new enhanced Medicare payments available for facilities that enroll as rural emergency hospitals. The new provisions will expand Medicare payment for mental health services furnished via telehealth even after COVID-19 waivers and flexibilities terminate. Teaching hospitals will be able to increase their GME FTE caps by applying for newly established GME Cap Slots and will be able to avoid triggering extremely low PRAs and GME FTE caps by hosting resident rotators. Hospitals located in rural areas and in states with medical schools that applied for accreditation after 2000 will be particularly well-positioned to apply for the newly established GME Cap Slots that will be made available starting in FY 2023. The establishment of rural emergency hospitals as a new provider type eligible for Medicare payment presents an opportunity for certain facilities in rural areas to convert to this new designation and receive payments that reflect some of the higher costs associated with furnishing emergency services in rural areas, without having to provide inpatient services.

For further information, please contact Allison Cohen or any member of Baker Donelson's Reimbursement Team.