

COVID-19: Legislative and Regulatory Impact and Opportunity



Netsmart

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Summary

In March, Congress passed and President Trump signed three historic bills designed to mitigate the effects of the COVID-19 (coronavirus) pandemic on the nation's health and economy. These bills are summarized as follows.

Coronavirus Aid, Relief, and Economic Security (CARES) Act

Funding: \$2 trillion+

This legislation is a financial package designed to stabilize the economy and provide assistance to individuals, families and businesses.

Families First Coronavirus Response Act

Funding: \$185 billion

This legislation responds to the COVID-19 outbreak by providing paid sick leave, tax credits and free COVID-19 testing. It also expands food assistance and unemployment benefits for Americans impacted by shutdown of the economy. The legislation increases Medicaid funding to states to help them provide care and fill a hole in their budgets created by lost tax revenue.

Coronavirus Preparedness and Response Supplemental Appropriations Act

Funding: \$8.3 billion

This piece of legislation contains emergency funding for federal agencies to respond to the COVID-19 outbreak, including research and development for vaccines, therapeutics and diagnostics. It also includes waivers removing restrictions on Medicare providers, allowing them to offer telehealth services to beneficiaries regardless of whether the beneficiary is in a rural community.

The following pages primarily summarize the CARES Act, but we have included relevant items from the other two bills, which we believe will impact Netsmart clients.

The Federal agencies responsible for each section of the CARES Act are developing implementation processes and guidance for their respective sections of the legislation over the next few weeks and months. At this time, Netsmart recommends that all clients follow these developments and support the key lobbying request from your respective trade associations such as: National Council for Behavioral Health, LeadingAge, the National Association for Home Care & Hospice and others as they work to shape the regulations that will be promulgated by these departments of the government. Netsmart will continue to advocate on our clients' behalf in conjunction with these industry associations. In addition, the federal agencies have adopted new regulations, temporarily modified existing regulations or issued

regulatory guidance to improve access to care effective until or after the end of the emergency declaration. These changes will affect your use of Netsmart solutions and other technology. In the second chapter of this document, we highlight where these changes impact your technology plans and how we are supporting you in meeting these new care delivery models.

Chapter one provides a summary of the key sections of CARES Act. To make it easier to follow, we provide codes to highlight which community each section of the CARES Act applies to allow you to rapidly find sections that impact your organization. The codes are:

BH – Behavioral Health

CFS – Child and Family Services

HH – Home Health

HO – Hospice

I/DD – Intellectual and Developmental Disabilities

IRF – Inpatient Rehab Facilities

LTAC – Long-Term Acute Care

PH – Public Health

SL – Senior Living

SS – Social Services

SUD – Substance Use Disorder

Chapter 1 – Legislation addressing COVID-19

1.1 CARES Act

1.1.1 Division A: Keeping Workers Paid and Employed, Health Care System Enhancements and Economic Stabilization

Title I — Keeping American Workers Paid and Employed Act

Sec. 1102. Paycheck Protection Program (\$349B)

Provides \$349 billion of 100% federally guaranteed loans to small businesses with 500 or fewer employees (total of full-time, part-time or any other status) who were doing business as of Feb. 15, 2020. This act also covers individuals who operate as a sole proprietor or independent contractor (i.e. the “gig economy”), with no collateral requirements. Businesses in certain industries can have more than 500 employees if they meet applicable [SBA employee-based size standards](#) for those industries. The maximum loan amount is 2.5 times the average monthly payroll of the borrower for the last 12 months—up to a maximum loan amount of \$10,000,000. Intent is that these loans will eventually be “forgiven” by the U.S. Government and will turn into grants if an employer maintains its payroll during the crisis or restores their payroll after. The individual salary per employee is capped at \$100,000 in this calculation. For organizations that are owned or invested in by private equity firms or venture capital firms, the “affiliated ownership” regulations will probably not allow you to participate in this program since your staffing counts will be affiliated with all other companies owned by the private equity firm and you will not meet the employee size requirement.

- Agency: SBA
- Communities: All
- Other reference material: [McBee White Paper: Small Business Emergency Loan Programs in the Wake of the COVID-19 Pandemic](#)

Sec. 1102. Emergency EIDL Grants (\$10B)

Provides a \$10,000 emergency advance to be paid out within three days of applying for an SBA Economic Injury Disaster Loan (EIDL), which offers up to \$2 million in assistance and can provide vital economic support to small businesses to help overcome the temporary loss of revenue. To qualify for these loans, the business must show a 50% decrease in gross receipts as compared to the same quarter one year ago.

- Agency: SBA
- Communities: All
- Other reference material: [McBee White Paper: Small Business Emergency Loan Programs in the Wake of the COVID-19 Pandemic](#)

Title III—Supporting America’s Healthcare System in the Fight Against the Coronavirus

Sec. 3211. Supplemental awards for health centers (\$1.32B)

Provides up to \$1.32 billion for fiscal year 2020 in supplemental funding to community health centers for the detection of SARS-CoV-2 or the prevention, diagnosis and treatment of COVID-19.

- Agency: HRSA
- Communities: BH

Sec. 3212. Telehealth network and telehealth resource centers grant programs (\$145M)

This section reauthorizes the Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for healthcare delivery, education and health information services. It provides \$29 million for each FY 2021-2025 to use telehealth to provide flexibility for patients with, or at risk of contracting, COVID-19 to access screening or monitor symptoms and care while avoiding exposure to others.

- Agency: HRSA
- Communities: All
- Other reference material: [HRSA Grant Information](#)

Sec. 3213. Rural healthcare services outreach, rural health network development, and small healthcare provider quality improvement grant programs (\$397.5M)

This section reauthorizes \$79.5 million for each FY 2021-2025 to HRSA for grant programs to strengthen rural community health, including through evidence-based or innovative evidence-informed models and the development of integrated collaborative healthcare networks. Grant award periods under this provision may not be longer than five years. Rural residents are disproportionately older and more likely to have a chronic disease, which could increase their risk for more severe illness if they contract COVID-19.

- Agency: HRSA
- Communities: All
- Other reference material: [HRSA grant information](#)

Sec. 3221. Confidentiality and disclosure of records relating to substance use disorder

This section substantially revises the 42 CFR Part 2 privacy statute, and tightly aligns it with HIPAA to permit a single patient consent (if that patient so chooses) for sharing of his or her substance use disorder (SUD)-related health data with their care provider. It also now allows for the redisclosure of the health data to covered entities and business associates as defined under HIPAA. Significantly, these changes now allow Netsmart SUD treatment providers to participate in health information exchanges, which often had barred their participation in the past. This will allow you to more easily be a part of integrated networks and CCBHCs. The changes to this statute will help prevent delays in diagnosis and treatment for persons with a SUD, many of who have untreated co-occurring medical conditions. It also reduces the risk to patients from errors in medical treatment or prescribing by giving providers a complete view of the person's health—physical and mental. Importantly, this section establishes new protections and penalties against the use of substance use medical records for discriminatory purpose or in legal and administrative settings and provides for enforcement of violations under HIPAA.

- Agency: SAMHSA
- Communities: All
- Other reference material: [Long-Term Advocacy Effort Pays Off With Patient-Centered Changes to 42 CFR Part 2 Privacy Regulations](#)

Sec. 3222. Nutrition Services

This section grants the Health and Human Services (HHS) Secretary the authority, for the duration of the public health emergency, to allow states and area agencies on aging to reallocate certain Nutrition Services Program funding (made available through the Older Americans Act) to meet local needs. Importantly, as in other sections, this section redefines the meaning of “homebound” to include individuals who are practicing social distancing due to COVID-19. This section opens an additional potential funding stream and service opportunities for home health and senior living providers in their

local communities during the public health emergency, and for behavioral health and I/DD providers in their residential and group home service lines.

- Agency: HHS
- Communities: HH, HO, SL, BH, I/DD

Sec. 3703. Increasing Medicare telehealth flexibilities during emergency period

This section broadens the authority of the Secretary of HHS to waive the telehealth requirements of section 1834(m) of the Social Security Act during the emergency period. This would enable Medicare beneficiaries to access telehealth, including in their home, from a broader range of providers, reducing COVID-19 exposure.

- Agencies: CMS/HHS
- Communities: BH, SUD, I/DD, SS, HH, HO
- Other reference material: [Medicare Telemedicine Health Care Provider Fact Sheet](#)

Sec. 3704. Enhancing Medicare telehealth services for Federally qualified health centers and rural health clinics during emergency period

This section allows Federally Qualified Health Centers (FQHCs) (including Community Health Centers (CHCs)) and Rural Health Clinics (RHCs) to furnish telehealth services to Medicare beneficiaries, including in the beneficiaries' homes to avoid potential exposure to COVID-19. Medicare would be required to pay FQHCs and RHCs for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. This section would also exclude the costs associated with these telehealth services from both the FQHC prospective payment system and the RHC all-inclusive rate calculations.

- Agencies: CMS/HHS
- Communities: BH, SUD, SS, I/DD, HH
- Other reference material: [Medicare Telemedicine Health Care Provider Fact Sheet](#)

Sec. 3706. Use of telehealth to conduct face-to-face encounter prior to recertification of eligibility for hospice care during emergency period

This section allows a Medicare hospice beneficiary to satisfy the face-to-face encounter requirements via telehealth visits with a hospice physician or nurse practitioner during the emergency period. This grants hospice providers much-needed flexibility to use telehealth as an efficient, viable option for the face-to-face encounter. This section corrects an omission that left out hospice providers when it included other home care service providers. **See Regulations section for more detailed analysis.**

- Agency: HHS
- Communities: HO

Sec. 3707. Encouraging use of telecommunications systems for home health services furnished during emergency period

This section requires the Secretary of HHS to issue clarifying guidance encouraging the use of telecommunications systems, including remote patient monitoring, to furnish home health services consistent with the beneficiary care plan during the emergency period. Currently, home health (and hospice) providers can conduct telehealth visits to augment their care planning, but they are not billable, nor do they count toward their billing and visit thresholds. **See Regulations section for additional analysis.**

- Agency: HHS

- Communities: HH, HO
- Additional material: [Telehealth](#)

Sec. 3708. Improving care planning for Medicare home health services

This section improves the care planning process for covered home health services by permitting a nurse practitioner or clinical nurse specialist working in accordance with state law or a physician assistant under the supervision of a physician to certify eligibility for home health services and establish and periodically review a plan for furnishing such services to an individual.

- Agencies: CMS/HHS
- Communities: HH

Sec. 3709. Adjustment of sequestration

Beginning May 1, 2020 through Dec. 1, 2020, this section suspends the mandatory 2% Medicare sequestration cuts in reimbursement to provide more funding to healthcare providers. Medicare plans and providers will receive a 2% increase in reimbursement during this time; however, it does extend the sequestration cuts by an additional year, now ending in 2030.

- Agencies: CMS/HHS
- Communities: All

Sec. 3711. Increasing access to post-acute care during emergency period

This section provides acute care hospitals flexibility during the emergency period to transfer patients out of their facilities and into alternative care settings in order to prioritize resources needed to treat COVID-19 cases. Specifically, it waives the inpatient rehabilitation facility (IRF) three-hour rule, which requires that a beneficiary be expected to participate in at least three hours of intensive rehabilitation at least five days per week to be admitted to an IRF. It also waives clinical criteria for long-term care hospital (LTCH) admissions and payments, allowing LTCHs to receive Medicare LTCH payments even if more than 50% of its cases do not meet such criteria. It would also temporarily pause the LTCH site-neutral payment methodology, therefore reimbursing LTCHs at the LTCH PPS rate for all admissions. Note: The 1135 waiver provided Medicare with the authority to respond to the emergency and follow rules set forth in section 1861(i) of the Social Security Act, which allows Medicare to cover patients affected by the emergency without a three-day inpatient hospital or nursing home stay prior to the emergency.

- Agencies: CMS/HHS
- Communities: IRF, LTAC, SNF

Sec. 3712. Revising payment rates for durable medical equipment under the Medicare program through duration of emergency period

This section prevents scheduled reductions in Medicare payments for durable medical equipment, helping patients transition from hospital to home and remain in their home. Effective through the emergency period.

- Agencies: CMS/HHS
- Communities: HH, HO

Sec. 3715. Providing home and community-based services in acute care hospitals

This section allows state Medicaid programs to pay for direct support professionals and caregivers trained to help with activities of daily living that assist individuals with disabilities in the hospital and

acute care settings to help reduce length of stay, free up beds and ensure individuals with disabilities receive appropriate care.

- Agencies: CMS/HHS
- Communities: HH/IDD

Sec. 3814. Extension and Expansion of Community Mental Health Services Demonstration Programs (CCBHCs) (\$377M)

This section extends funding for the current eight-state CCBHC demonstration by \$377 million through Nov. 30, 2020, and we fully expect further legislation to extend beyond that date. It also expands the program by two additional states to be identified by the Secretary of HHS from among states that applied but were not accepted for the first demonstration program. We expect this program expansion will move rapidly, so Netsmart clients should start preparing quickly if your state was one of the states that applied for the CCBHC demonstration program but was not accepted for the original program. Netsmart was a strong advocate for this legislation.

- Agencies: HHS/CMS
- Communities: BH and SUD

Title IV—Economic Stabilization and Assistance to Severely Distressed Sectors of the United States Economy

Section 4027. Direct Appropriation. (\$500B)

The bill appropriates \$500,000,000,000 to carry out this title.

Main Street New Loan Facility (\$75B from CARES Act, up to \$600B total for program)

This program, not included in the CARES Act but funded in part by this section and authorized under section 13(3) of the Federal Reserve Act, took effect April 9, and facilitates lending to small and medium-sized businesses by Eligible Lenders: U.S. insured depository institutions, U.S. bank holding companies, and U.S. savings and loan holding companies. Under the Facility and the Main Street Expanded Loan Facility (MSELF), a Federal Reserve Bank will commit to lend to a single common special purpose vehicle (SPV) on a recourse basis. The SPV will purchase 95% participations in Eligible Loans from Eligible Lenders. Eligible Lenders would retain 5% of each Eligible Loan. The Department of the Treasury, using funds appropriated to the Exchange Stabilization Fund under section 4027 of the CARES Act, will make a \$75 billion equity investment in the single common SPV in connection with the Facility and the MSELF. The combined size of the Facility and the MSELF will be up to \$600 billion.

Eligible Borrowers are businesses with up to 10,000 employees or up to \$2.5 billion in 2019 annual revenues. Each Eligible Borrower are U.S.-based businesses with significant operations in and a majority of its employees based in the U.S.

An Eligible Loan is an unsecured term loan made by an Eligible Lender(s) to an Eligible Borrower, and includes the following features:

- 4-year maturity
- Amortization of principal and interest deferred for one year
- Adjustable rate of SOFR + 250-400 basis points
- Minimum loan size of \$1 million
- Maximum loan size that is the lesser of (i) \$25 million or (ii) an amount that, when added to the Eligible Borrower's existing outstanding and committed but undrawn debt, does not

exceed four times the Eligible Borrower's 2019 earnings before interest, taxes, depreciation, and amortization (EBITDA)

- Prepayment permitted without penalty

Other conditions include:

- The Eligible Lender must attest that the proceeds of the Eligible Loan will not be used to repay or refinance pre-existing loans or lines of credit made by the Eligible Lender to the Eligible Borrower
- The Eligible Borrower must commit to refrain from using the proceeds of the Eligible Loan to repay other loan balances. The Eligible Borrower must commit to refrain from repaying other debt of equal or lower priority, with the exception of mandatory principal payments, unless the Eligible Borrower has first repaid the Eligible Loan in full.

Borrowers must also follow compensation, stock repurchase, and dividend restrictions that apply to direct loan programs under the CARES Act. Firms that have taken advantage of the Paycheck Protection Program may also take out Main Street loans.

- Communities: All
- Other reference materials:
 - [Main Street Loan Facility](#)
 - [Federal Reserve News Release](#)

1.1.2 Division B, Emergency Appropriations for Coronavirus Health Response and Agency Operations

FCC COVID-19 Telehealth Program and Connected Care Pilot Program (\$300M)

Telehealth Program (\$200 million)

This program supports healthcare providers responding to the pandemic with full funding to purchase telecommunications services, information services and devices necessary to enable the provision of telehealth services during the emergency period. Eligibility is limited to public and non-profit healthcare providers to include: community mental health centers, local health departments or agencies, not-for-profit hospitals, rural health clinics, skilled nursing facilities, community health centers or health centers providing health care to migrants, post-secondary educational institutions offering health care instruction, teaching hospitals and medical schools, and consortia of healthcare providers consisting of one or more entities falling into the first seven categories.

The application process opened on April 13. Visit the [COVID-19 Telehealth Program Web page](#) for instructions and to download a fillable PDF [COVID-19 Telehealth Application form](#). There is also an [instructional video](#) on completing the application.

Connected Care Pilot Program (\$100 million)

A separate three-year Connected Care Pilot Program to be launched at a later date will provide up to \$100 million of support from the Universal Service Fund (USF) to help defray healthcare providers' costs of providing connected care services and to help assess how the USF can be used in the long-term to support telehealth. The goal for the Pilot Program is to determine how financial support from the USF can enable the selected providers to: (1) improve health outcomes through connected care; (2) reduce health care costs for patients, facilities and the health care system; and (3) support the

trend toward connected care everywhere. Netsmart clients among the entities cited for eligibility include community mental health centers, outpatient mental health and substance abuse centers, psychiatric and substance abuse hospitals, home care health services, and skilled nursing facilities. The FCC states they have a “strong preference” for healthcare providers who have either experience with providing telehealth or connected care services to patients (e.g., remote patient monitoring, store-and-forward imaging, or video conferencing) beyond using electronic health records or are partnering with an organization with that experience.

The FCC will issue a public notice announcing the effective date of the Pilot Program rules and deadline for submitting applications. They will also provide a Connected Care Pilot Program Application form that applicants must use to submit project proposals.

- Agency: FCC
- Communities: BH, SUD, PH, PS, HH, SL
- Other reference material: [F\\$100CC Statement](#)
- [Detailed Guidance](#) on the FCC Telehealth Program application process
- [FCC Report and Order](#) (details about the Telehealth Program and the Connected Care Pilot Program)

Title VIII – Department of Labor, Health and Human Services, Education, and Related Agencies

Centers for Disease Control and Prevention (\$500M)

This section provides \$500 million for public health data surveillance and infrastructure modernization efforts at the CDC, state, and local health departments. This funding, which must be expended by Sep. 30, 2024, can provide public health organizations the ability to shift from reactive to proactive approaches for identifying and tracking the coronavirus and other communicable diseases.

- Agency: CDC
- Communities: PH

Public Health and Social Services Emergency Fund (\$100B)

This \$100 billion program is in many ways the heart of the CARES Act. It provides grants to hospitals, public entities, not-for-profit entities, and Medicare and Medicaid enrolled suppliers and institutional providers to cover unreimbursed healthcare-related expenses or lost revenues attributable to the Public Health Emergency resulting from the coronavirus. It will reimburse for a wide range of items such as personal protective equipment, medical devices, and building and facility expenses. Broad eligibility that includes hospitals and items in significant demand will create large demand for the grants, so it is important for our clients to move quickly and to support their trade associations in their lobbying efforts. Netsmart and many of its association partners, including the National Council for Behavioral Health, National Association for Home Care & Hospice, the Partnership for Quality Home Healthcare, LeadingAge and others are submitting letters stating the compelling need/importance to include human services and post-acute providers fully in this grant program. Home health and hospice providers are among organizations receiving dollars from the first \$30 billion of the fund distribution, to facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019. The subsections below describe the major areas of funding.

- Agency: Assistant Secretary for Preparedness and Response
- Communities: All

Health Resources and Services Administration (\$275M)

The bill includes \$275 million for HRSA, including \$90 million for Ryan White HIV/AIDS programs and \$185 million to support rural critical access hospitals, rural tribal health and telehealth programs, and poison control centers.

- Agency: HRSA
- Communities: All

Administration for Community Living (ACL) (\$955M)

This section includes \$955 million for ACL to support nutrition programs, home and community-based services, support for family caregivers, and expand oversight and protections for seniors and individuals with disabilities. \$85 million will be available for centers for independent living that have received grants funded under part C of chapter I of title VII of the Rehabilitation Act of 1973.

- Agency: HRSA
- Community: I/DD, HH, SL

Centers for Medicare & Medicaid Services (CMS) – Nursing Homes (\$200M)

This section includes \$200 million for CMS to assist nursing homes with infection control and support states' efforts to prevent the spread of coronavirus in nursing homes

- Agency: CMS
- Communities: SL

Centers for Medicare & Medicaid Services (CMS) – Mental Health Services (\$425M)

This section includes \$425 million for SAMHSA to increase access to mental health services through CCBHCs, Community Mental Health Centers (CMHCs), suicide prevention programs and emergency response spending that can target support where it is most needed, such as outreach to those experiencing homelessness. \$250 million for the SAMHSA CCBHC grant program; \$50 million for suicide prevention programs; \$100 million for SAMHSA programs generally and \$15 million for tribes.

Note: The \$250 million mentioned above is allocated to the SAMHSA CCBHC grant program, but will be broadly interpreted to allow CMHCs to apply for the funding for use outside of the CCBHC grant program. The SAMHSA CCBHC grant program is separately funded from the Medicaid CCBHC demonstration program described in the summary of [Section 3814](#).

Full details on how the funds will be distributed are not yet available.

- Agency: SAMHSA
- Communities: BH, SUD

Centers for Medicare & Medicaid Services (CMS)–Child Care Block Grant

This section includes \$3.5 billion for the Child Care Development Block Grant. This funding will allow childcare programs to maintain critical operations, including meeting emergency staffing needs and ensuring first responders and healthcare workers and others can access childcare while they respond to the pandemic.

- Agency: CMS
- Communities: TBD at state level

Title X–Veterans Affairs and Related Agencies

Facilities and IT Support for Telemedicine (\$3.1B)

This section includes \$3.1 billion for the VA to purchase, staff, and equip temporary sites of care and mobile treatment centers to deal with this pandemic. It allows for remodeling of VA facilities and state-run veterans homes to address the needs of veterans being treated for coronavirus. The bill includes

funding for the VA to expand the capacity on existing IT networks to address the demand in services and broadens VA's tele-ICU and teleradiology capabilities. It further enhances the capability for telehealth visits, allowing more veterans to receive care from home, and for providers at home to continue to treat individuals through technology. Additionally, it facilitates VA employees working from home to ensure benefits can still be processed.

- Agency: Veterans Administration
- Communities: BH, SUD, HH

Title XII–Dept. of Transportation and Housing

Community Development Block Grant (\$5B)

This section includes \$5 billion for the Community Development Block Grant (CDBG) program to enable nearly 1,240 states, counties, and cities to rapidly respond to COVID-19 and the economic and housing impacts caused by it, including the expansion of community health facilities, childcare centers, food banks and senior services. Of the amounts provided, \$2 billion will be allocated to states and units of local governments that received an allocation under the fiscal year 2020 CDBG formula. \$1 billion will go directly to states to support a coordinated response across entitlement and non-entitlement communities, and \$2 billion will be allocated to states and units of local government, cities and counties based on the prevalence and risk of COVID-19 and related economic and housing disruption

- Communities: All

1.2 Coronavirus Preparedness and Response Supplemental Appropriations Act

This legislation appropriated \$8.3 billion to address COVID-19. Its major components are highlighted below.

Health Agency Funding (\$2.2B)

This section provides \$2.2 billion to support federal, state, and local public health agencies to prevent, prepare for, and respond to the coronavirus, including \$950 million for state and local response efforts, of which \$475 million must be allocated within 30 days of the enactment of the bill. This funding can provide public health organizations the ability to shift from reactive to proactive approaches for identifying and tracking the coronavirus and other communicable diseases.

- Agency: HHS
- Communities: PH

Health Agency Grants

This section includes grants to, or cooperative agreements with, states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes, to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications and other preparedness and response activities.

- Agency: HHS
- Communities: PH

1.3 Families First Coronavirus Response Act

This was the second major piece of legislation passed by Congress. It appropriates \$185B to provide paid sick leave, tax credits and free COVID-19 testing, and expands food assistance and

unemployment benefits for Americans impacted by shutdown of the economy. It increases Medicaid funding to the states to help them provide care and fill a hole in their budgets created by lost tax revenue. It allocates \$185 billion to provide paid sick leave, tax credits and free COVID-19 testing, and expands food assistance and unemployment benefits for those Americans impacted by shutdown of the economy. It also increases Medicaid funding to the states to help them provide care and fill a hole in their budgets created by lost tax revenue.

Temporary Increase to Medicaid FMAP

This section provides for a temporary 6.2% increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) effective beginning Jan. 1, 2020 and extending through the last day of the calendar quarter in which the Public Health Emergency declared by the Secretary of HHS for COVID-19. This is designed to provide immediate funding to the state health systems being overwhelmed by COVID-19 patients and to help offset lost state tax revenue caused by unemployed workers.

- Agencies: CMS/HHS
- Communities: All

1.4 Emergency Declaration and Burden Relief

Expands telehealth access for Medicare–CMS

In conjunction with the CARES Act, CMS announced changes in Medicare regulations and payment policies for the use of telehealth services in evaluation and treatment of beneficiaries. This expands the 'originating site of service' and allows Medicare to pay for physician office, hospital and other visits done via telehealth (including in patient's home) until the end of the COVID-19 Public Health Emergency declaration. A range of health professionals, including physicians, physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, clinical nurse specialists and registered dietitians or nutrition professionals will be able to offer telehealth.

- Allows for physician face-to-face visits, required at specific time points for home health, hospice, and senior living benefits, to be completed by an approved professional utilizing telehealth technology.
- Technology does not require video and can be conducted by voice only.
- Allows hospices to use telecommunication systems to furnish services during a Public Health Emergency. Usage must be included in the Plan of Care.
- Telehealth visits performed by home health and hospice providers are not considered 'billable' and should not be put on a bill. They are considered administrative costs to augment the plan of care and can be included in the cost report.
- Home health telehealth visits do not count toward minimum thresholds for Low Utilization Payments.
- Hospice can only utilize telehealth visits under the Routine Home Care level of care and are considered part of the per diem rate.
- Hospice chaplain and social work visits can be conducted via telehealth during end of life services, as they are considered essential visits during this time.
- Communities: HH, HO, SL, IRF
- Other reference material: [CMS Medicare Telemedicine Healthcare Provider Fact Sheet](#), [Medicare Telehealth FAQs](#)

Reiteration of telehealth permissibility under Medicaid–CMS

CMS also issued updated FAQs to State Medicaid offices and CHIP agencies that included a reminder that no federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate the states pay for face-to-face services.

- Communities: Awaiting State updates
- Additional reference material: [FAQs for State Medicaid and Children’s Health Insurance Program \(CHIP\) Agencies](#) (telehealth info starts on p. 5)

Use of telemedicine for DEA-registered providers – DEA

For as long as the Secretary’s designation of a Public Health Emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances, including distance prescribing as well as dispensing of buprenorphine by opioid treatment programs (OTP) to patients for whom they have not conducted an in-person medical evaluation, provided all the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time two-way interactive communication system
- The practitioner is acting in accordance with applicable federal and state law

- Communities: BH, SUD, HO, SL
- Additional reference material: [DEA Guidance Letter](#)

Medicare appeals, financial considerations and audits

Appeals–CMS allows Medicare Administrative Contractors (MACs) to:

- Allow extensions in filing appeals
- Waive requirements for timeliness for request for additional information to adjudicate appeals

Accelerated/Advanced payments–allows providers to submit requests for accelerated or advanced payment from their MAC with an extension in the repayment. More information can be found in the [CMS Accelerated and Advanced Payments Fact Sheet](#).

Cost Reporting–delay in filing deadline for cost reports. October and November 2019 fiscal year-end cost reports will be due June 30, 2020. December 2019 fiscal year end cost reports will be due July 31, 2020.

Suspension of Audit activities–suspension of Fee-for-Service (FFS) medical reviews, including pre-payment reviews, Targeted Probe and Education (TPE), post-payment reviews, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC) audits. No Additional Documentation Requests (ADRs) will be issued during the PHE. Current audits in process will be suspended and released.

1.5 Other Post-Acute Regulatory Burden Relief

This section highlights key regulatory changes that effect Netsmart clients. These changes, in effect until the end of the national emergency unless otherwise noted, have been promulgated through 1115, 1135 and other waivers issued by CMS.

Senior Living

- 3-Day Prior Hospitalization requirement—the 1135 waiver allows Medicare to cover beneficiaries in SNF care without a 3-day inpatient hospital stay until the end of the national emergency.
- MDS—waives timeframes for submitting MDS. Timeframes not yet specified.
- Payroll Based Journal system—waives submission of staffing data.
- PASARR—allows states and nursing homes to suspend assessments for new residents for 30 days; after 30 days patients with a mental illness or intellectual disability should receive the assessment as soon as resources are available.
- Physical environments—allows for beds and rooms to be used as needed for care and treatment of COVID-19 patients and surge capacity.
- Resident Groups—waives requirement for in-person resident groups.
- Roommates—waives requirement to allow a resident to share a room with a person of their choice or refusal to transfer to another room. This is solely for the purposes of grouping or cohorting residents with respiratory illness or confirmed COVID-19 away from those who are asymptomatic or negative for COVID-19.
- Transfer/Discharge—allows LTC facility to transfer or discharge residents to another LTC facility solely for cohorting COVID-19 positive patients (if that facility is dedicated to the care of such residents), transferring residents without symptoms or confirmed negative COVID-19 (if that facility is dedicated to care for residents to prevent acquiring the disease), and transferring residents without symptoms to another facility to observe for signs or symptoms over the next 14 days.
- Training/Certification of Nurse Aides—waives requirements in training and certification for nurse aides in light of staffing shortages in pandemic.
- ESRD services—allows dialysis facilities to provide services to patients directly in a SNF/NF.
- Delays MDS 3.0 v1.18.1 implementation—this update removes section G from the OBRA assessment.

Home Health

- Review Choice Demonstration—suspended effective March 29,2020, further instructions will be provided when the project resumes.
- Homebound Definition—updates to include beneficiaries who are advised to remain home by their physician or if they have a condition which makes them more susceptible to contract COVID-19.
- Request for Anticipated Payments—allows MACs to extend the auto-cancellation dates.
- OASIS Reporting—relieves OASIS transmission timeframes; extends the five-day completion. Requirement for the comprehensive assessment to 30-days. Waives the 30-day OASIS submission requirement. OASIS submission is still required before claims can be submitted for home health services.

- Initial assessments—allows the initial assessment and determination of homebound status to be conducted remotely or by record review.
- Aide supervision—waives requirement for nurse to conduct onsite visit every two weeks and two-week aide supervision by RN. Virtual supervision is encouraged during the waiver.
- Medicaid Home Health Services and Equipment—allows non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, physical therapy, occupational therapy or speech pathology and audiology services in accordance with state scope of practice laws.
- COVID-19 Testing—allows testing by home health nurse if beneficiary is already receiving Medicare home health services.

Hospice

- Volunteers—waives requirement to use volunteers.
- Comprehensive assessment—must continue to complete required assessments and updates, but timeframe may be extended from 15 to 21 days.
- Non-Core services—waives requirement to provide non-core services for PT, OT, and SLP.
- Aide supervision—waives requirement for nurse to conduct onsite visit every two weeks and two-week aide supervision by RN.

Chapter 2 – Netsmart solutions to assist during COVID-19

This chapter outlines Netsmart solutions that help our clients meet the regulatory and clinical needs imposed by the pandemic in general and the regulations highlighted in Chapter 1.

2.1 Electronic Health Records Expansion

Bill Sections: [3708](#), [3211](#), [3814](#), Indian Health Services (IHS), Health Resources and Services Administration (HRSA), Administration for Community Livings (ACL)

As part of the series of legislative vehicles described in Chapter 1, Congress recognized the burden placed on provider organizations by the pandemic and has provided funding for providers to adapt their technology investments to meet the needs of equipping a remote workforce and sheltered in place patients. The need to protect patients as well as caregivers has driven most of these changes. Netsmart clients have the ability to apply for funding to enhance their current EHR with additional solutions and services to adapt to this new care environment. In the legislation there is an emphasis on home and community-based services to support caregivers to expand oversight and protections for seniors and individuals with disabilities. Our suite of post-acute EHRs can assist agencies with ensuring non-physician visits can be completed and are accepted under the new beneficiary definitions specific to post-acute. In addition, there are numerous sections applicable to human services and post-acute providers, as referenced above, that will appropriate funding if you are utilizing your EHR to provide services in any of the care settings below:

- Addictions
- Assisted Living
- Behavioral Health
- Child Welfare
- Home Care
- Hospice
- Independent living
- Inpatient Hospice Units
- Intellectual/Developmental Services
- Palliative Care
- Skilled Nursing
- PACE
- Primary Care
- Public Health

In helping our clients respond to the rapidly evolving needs associated with COVID-19, we have noted that those clients with a comprehensive suite of capabilities integrated with the EHR have been best positioned to respond. Netsmart has reacted very quickly to assist in many areas including the creation of the COVID-19 screening tools and the KPI COVID-19 Monitoring Dashboard. Below is additional information for each EHR.

Advisor

- [Advisor COVID-19 Screener](#)
- [Advisor Telehealth](#)

myAvatar

- [myAvatar COVID-19 Screener](#)
- [myAvatar Integrated Telehealth](#)
- [COVID-19 Monitoring Dashboard Activation Instructions](#)

myEvolv

- [myEvolv COVID-19 Screener](#)

- [myEvolv Integrated Telehealth](#)
- [COVID-19 Monitoring Dashboard Activation Instructions](#)

myUnity Home Care and Hospice Resources

- [myUnity Home Care and Hospice COVID-19 Screener](#)
- [COVID-19 Monitoring Dashboard Activation Instructions](#)
- [myUnity Telehealth](#)

myUnity Senior Living

- [myUnity Senior Living COVID-19 Screener](#)
- [COVID-19 Monitoring Dashboard Activation Instructions](#)
- [myUnity Telehealth](#)
- [Referral Manager Now](#)

Netsmart Homecare and Hospice

- [Netsmart Homecare and Hospice COVID-19 Screener](#)
- [Telehealth](#)

Netsmart Homecare and Hospice

- [COVID-19 Resource Center](#)

myInsight

- [myInsight COVID-19 Screener](#)
- [myInsight Integrated Telehealth](#)
- [COVID-19 Monitoring Dashboard Activation Instructions](#)

Additional examples of capabilities that could be considered as part of EHR expansion work might include expanding to meet FQHC reporting requirements or enabling real-time data sharing if you are partnering with a FQHC via our interoperability solutions. Investing to support secure data sharing across local health information exchanges (HIEs) as well as connecting to the large interoperability framework, [Carequality](#), should be considered. Importantly, prioritizing an interoperability strategy based on leveraging a standards-based network like Carequality might carry important advantages, such as not being reliant on a proprietary network but instead leveraging industry standards to exchange and integrate data.

It is likely your health system partners will be thinking of how to handle an influx of incoming patients, likely by the hundreds and thousands, regardless of if that happens in their location with COVID-19. In this scenario they are, or will be, focused on discharging patients that are not critically ill to free up beds for COVID-19 patients as part of this crisis. The ability to query their EHR using Carequality will allow you to receive patient data in real time as opposed to the legacy methodology that may have taken weeks for their discharge planners and medical records teams to deliver to you based on the sheer volume of requests they are receiving. Conversely, if you need to send one of your patients to a hospital that is admitting an influx of patients, the ability to send your patient's clinical record electronically will reduce the admission burden on the receiving hospital and reduce the potential errors of keying in the data manually. Thus, the importance of investments to continue to advance your EHR's interoperability capabilities.

- For information about these extended EHR capabilities as they relate to your Netsmart EHR and CareFabric solutions: [myAvatar](#), [myEvolv](#), [myUnity](#), [CarePathways Measures Reporting](#), [CarePOV](#)

[Medical Note for Primary Care](#), [CareConnect](#), [Carequality](#), [Applied Behavioral Analysis App](#) and [Telehealth](#).

2.2 Telehealth

Bill Sections: [3212](#), [3703](#), [3704](#), [3706](#), [FCC Connected Care Pilot Program](#), [Assistant Secretary for Preparedness and Response](#)

Due to COVID-19, much of healthcare has rapidly transitioned into a virtual care environment. As a result, during the national emergency CMS has relaxed its restrictions on HIPAA compliance to allow providers to engage with individuals over less secure methods of telehealth technology (PL 108-276) such as Zoom, Teams and Facetime. While this is permitted in the short term, we strongly believe that these the reduction in HIPAA requirements will drop immediately upon the end of the emergency, and you will be required to meet HIPAA compliance once again. It is important that your long-term telehealth strategy includes integration to your EHR, is HIPAA compliant and is designed to meet the unique needs of service delivery.

The bill sections referenced in Chapter 1 will enable organizations to seek funding for telehealth technology. While CMS has given providers flexibility with HIPAA waivers to adopt more general non-integrated versions of virtual conferencing, Netsmart clients have reported major shortcomings with unexpected ramifications. Most of these ramifications stem from workflow challenges as defined as follows: an extremely important point to remember is that the billing mechanisms for telehealth visits and phone calls have not been defined for the most part by CMS yet. A key benefit of the Netsmart Telehealth solution is that it is integrated with your EHR so we track telehealth sessions, both audio and video, so that when the billing mechanisms are defined, you can bill for them to receive your funding in a fully-auditable fashion. Zoom, Facetime and other systems DO NOT do this, and they put the onus on the provider to track each session, gather phone and call logs and associate them with the appropriate patient. A fully-integrated system will also automate the tracking of time for each of these sessions.

One of the largest family services organizations in New York City rapidly implemented telehealth in over 70 locations. Their initial findings indicate there is a substantial difference in workflow between an integrated telehealth solution versus a standalone solution.

- For more information about telehealth: [Telehealth](#) and [Definitive Guide for Leveraging Telehealth Whitepaper](#)

2.3 Interoperability

Bill Sections: [3211](#), [3213](#), [3221](#), [3814](#)

The sections referenced above offer funding opportunities to address the lack of integrated and coordinated care, especially in high-risk populations. This funding is designed to allow organizations to invest in technology with a focus on quality improvement, increased access to services and care coordination for underserved and at-risk populations. Organizations should consider creating proposals that enable population health management inclusive of advancing capabilities in the following areas: care coordination, interoperability among providers servicing populations with complex conditions, consumer and family engagement created by social isolation, virtual care and analytics, all from within in a single platform or from within their EHR. As stated in the CARES Act, proposals targeted toward improving care for vulnerable populations will likely be prioritized in funding requests. It is our hope that proposals inclusive of a strategy to equip care teams across multiple care settings

(primary care, behavioral health, home care and hospice and long-term care) would be received well. These initiatives could be designed to enable the care team access to the following:

- Longitudinal Patient View
- Hospitalization and Emergency Room Alerting
- Gaps in care monitoring and alerting
- Risk Stratification and Vulnerable Population Analytics
- Secure Data Exchange
- Referral Management
- Telehealth Services
- Outcomes and Key Performance Indicators

As described above, the ability to query hospital EHRs using Carequality will allow you to receive patient data in real time. Given that the healthcare system is experiencing drastic increases in volume of discharge patients, by having this capability you are avoiding bottlenecks at discharge planning inclusive of exchanging a comprehensive service record. Conversely, if you need to send one of your patients to a hospital that is admitting thousands of patients, the ability to send your patient's clinical record electronically will reduce the admission burden on the receiving hospital and reduce the potential errors of keying in the data manually.

Providers will have the opportunity to electronically connect to a network of providers supporting secure data sharing across local HIEs and large interoperability frameworks such as [Carequality](#). Carequality is a common interoperability framework to enable exchange between and among health data sharing networks.

- For information about care coordination and interoperability: [CareManager](#), [CareConnect](#), [Carequality](#), [Telehealth](#), [KPI Dashboards](#).

2.4 CCBHC

Bill Section: [3814](#)

As part of the COVID-19 stimulus legislation, the CCBHC program has been extended to Nov. 30, 2020, and we fully expect further legislation to extend beyond that date in future legislation. Netsmart has advocated alongside our clients and other stakeholders for the creation and extension of the CCBHC program, and we were proud to have played a role in the passage of the CCBHC original legislation and continued our advocacy efforts in support of the recent extension. The CCBHC program enables our clients to provide more fully-informed diagnosis and treatment based on a person's complete health record. The program is expected to continue well beyond November 2020 and will likely continue to move into other states. It also expands the program by two additional states to be identified by the Secretary of HHS from among states that applied but were not accepted for the first demonstration program. We expect that this program expansion will move rapidly so Netsmart clients should start preparing quickly if your state was one of the states that applied for the CCBHC demonstration program, but was not accepted in the original program

Organizations that reside in a state that originally applied to be a demonstration state, should be evaluating their capabilities to meet [CCBHC certification requirements](#) as it is possible this funding will be available to your organization imminently as the two additional expansion states are named. Additionally, our experience working with clients who have participated in the demonstration project indicates a thorough understanding of the cost of care across services lines is critical. Investments in the EHR in areas required to align to the Prospective Payment System and quality metrics reporting should be considered. In addition, capabilities beyond the EHR, such as interoperability, consumer

engagement, telehealth and analytics are needed to meet the certification criteria and excel in each of the required service lines. Netsmart has gained extensive experience deploying technology to support our clients across the eight demonstration states and the additional states that have received [SAMHSA CCBHC grants](#). In addition, we have developed and delivered statewide models with our client partners. Our CCBHC team can assist in providing a needs assessment review and a crosswalk to CCBHC requirements.

For CCBHCs and other providers wanting to expand into Medication-Assisted Treatment (MAT), our EHRs support the unique challenges of MAT programs by providing the ability to dispense all three FDA approved medications.

- For more CCBHC information please refer to the following: [FAQ](#), [CarePlus client success story](#), [myEvolvAM](#) and [myAvatarAM](#).