EMERGENCY RULE # 21-E08

Administrative Procedures – Emergency Rule Filing

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" (CVR 04-000-001) adopted by the Office of the Secretary of State, this emergency filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, the Legislative Committee on Administrative Rules and a copy with the Chair of the Interagency Committee on Administrative Rules.

All forms requiring a signature shall be original signatures of the appropriate adopting authority or authorized person, and all filings are to be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

This emergency rule may remain in effect for a total of 180 days from the date it first takes effect.

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801(b)(11) for a definition), I believe there exists an imminent peril to public health, safety or welfare, requiring the adoption of this emergency rule.

The nature of the peril is as follows (*PLEASE USE ADDITIONAL SHEETS IF SPACE IS INSUFFICIENT*). The nature of the peril is the continuing COVID-19 public health emergency(PHE) declared by Secretary of Health and Human Services Alex M. Azar on January 31, 2020. Please see also the Department's answer in paragraph 9.

I approve the contents of this filing entitled:

Access to Health Care Services Related to COVID-19

/s/ Michael S. Pieciak , on 6/28/2021

(signature) (date)

Printed Name and Title:

Michael S. Pieciak, Commissioner of Financial Regulation

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)

1. TITLE OF RULE FILING:
   Access to Health Care Services Related to COVID-19

2. ADOPTING AGENCY:
   Department of Financial Regulation

3. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Sebastian Arduengo

   Agency: Department of Financial Regulation

   Mailing Address: 89 Main Street, Montpelier, VT 05620 - 3101

   Telephone: 802 828 - 4846 Fax: 802 828 - 5593

   E-Mail: Sebastian.Arduengo@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   https://dfr.vermont.gov/about-us/legal-general-counsel/proposed-rules-and-public-comment

4. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Gavin Boyles

   Agency: Department of Financial Regulation

   Mailing Address: 89 Main Street, Montpelier, VT 05620 - 3101

   Telephone: 802 272 - 2338 Fax: 802 828 - 1919

   E-Mail: Gavin.Boyles@vermont.gov

5. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

6. LEGAL AUTHORITY / ENABLING LEGISLATION:

(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

This rule is issued under the authority vested in the Commissioner of Financial Regulation by Act 6 of 2021, section 8.

7. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

Act 6 of 2021, section 8, requires the Commissioner to consider adopting and gives the Commissioner authority to adopt emergency rules to:
(1) expand health insurance coverage for, and waive or limit cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention; and
(2) suspend health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.
Act 6 further gives the Commissioner authority to adopt the emergency rule until March 31, 2022 notwithstanding the requirements of the Vermont Administrative Procedures Act.

8. CONCISE SUMMARY (**150 WORDS OR LESS**):

The emergency rule requires health insurers to provide continuing coverage of COVID-19 diagnosis, testing, and treatment without member cost-sharing.

9. EXPLANATION OF WHY THE RULE IS NECESSARY:

A continued emergency rule regarding COVID-19 diagnosis, testing, and treatment is necessary because as of June 21, 2021, children under 12 are not yet eligible to receive an FDA-authorized COVID-19 vaccine and there have over 200 "breakthrough" cases (e.g., COVID-19 cases in fully-vaccinated patients), resulting in multiple hospitalizations and at least 3 deaths in Vermont.

10. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The emergency rule is not arbitrary because required coverage of COVID-19 diagnosis, testing, and treatment is limited to claims in which COVID-19 or suspected exposure to COVID-19 is the primary diagnosis

11. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

The emergency rule primarily affects health insurers, pharmacy benefit managers, and members of health insurance plans.

12. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters who still require access to COVID-19 testing and treatment.

Vermont's regulated health insurers continue to be in a strong financial position going into plan year 2022, and the emergency rule is not expected to have a material effect on their solvency or ability to pay claims.

13. A HEARING IS NOT SCHEDULED .

14. HEARING INFORMATION
(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION NEEDED FOR THE NOTICE OF RULEMAKING.

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

15. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING): 06/30/2021

16. EMERGENCY RULE EFFECTIVE: 07/01/2021

17. EMERGENCY RULE WILL REMAIN IN EFFECT UNTIL
(A DATE NO LATER THAN 180 DAYS FOLLOWING ADOPTION OF THIS EMERGENCY RULE):

03/31/2022

18. NOTICE OF THIS EMERGENCY RULE SHOULD NOT BE PUBLISHED IN THE WEEKLY NOTICES OF RULEMAKING IN THE NEWSPAPERS OF RECORD.

19. KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Health Insurance

COVID-19

Testing

Treatment

Administrative Procedures – Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Access to Health Care Services Related to COVID-19
2. ADOPTING AGENCY:
   Department of Financial Regulation
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment as long as the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **A NEW RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   The emergency rule supercedes emergency rule H-2020-06-E, SOS Log # 20-E22; Effective 10/22/20.

State of Vermont
Agency of Administration
Office of the Secretary
Pavilion Office Building
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322
[fax] 802-828-3320

Susanne R. Young, Secretary

MEMORANDUM

TO: **Jim Condos, Secretary of State**

FROM: **Kristin L. Clouser, ICAR Chair**

Kristin L. Clouser

Digitally signed by Kristin L. Clouser
Date: 2021.06.30 12:36:21 -04'00'

DATE: **June 30, 2021**

RE: **Emergency Rule Titled 'Access to Health Care Services During the COVID-19 Pandemic' by the Department of Financial Regulation**

The use of rulemaking procedures under the provisions of 3 V.S.A. §844 is appropriate for this rule. I have reviewed the proposed rule provided by the Department of Financial Regulation and agree that emergency rulemaking is necessary.

Administrative Procedures – Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

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1. TITLE OF RULE FILING:

   Access to Health Care Services Related to COVID-19

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters. The amount saved will vary depending on individual healthcare utilization and the COVID-19 infection rate in Vermont. As of June 21, 2021, the seven-day average infection rate stands at 5 new cases per day. The Department's modeling suggests a COVID-19 growth rate near 0% after June 1, 2021.

Based on auditing data and cost estimates provided to the Department and 2022 health insurance rate filings, the Department found that insurers' 2020 claims experience was significantly impacted by the COVID-19 pandemic. In particular, both MVP Health Care and Blue Cross and Blue Shield of Vermont saw a net decrease in overall claims paid from plan year 2019, with well below-average claims volume from March 2020 to July 2020, and above-average claims volume for the rest of the year.

Under the Affordable Care Act, Regulation H-2020-06-E, and this emergency rule, health insurers are required to cover the cost of vaccines recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP), including COVID-19 vaccines developed by Pfizer-BioNTech, Moderna, and Johnson & Johnson. In plan year 2020, MVP Health Care asked for an additional 1.0% to premium in its rate filing in anticipation of covering one dose of a COVID-19 vaccine priced at $75 for 80% of its members. Because approximately 821,000 doses of the three vaccines have been administered in Vermont as of June 21, 2021, representing over 80% of the population eligible for vaccination, the Department does not anticipate siginificant additional future costs to health insurers for vaccines. Even if booster shots are needed in the next 10 months to protect against emerging variants of COVID-19, MVP Health Care estimates that the cost will be $1.14 per member per month, representing a fraction of a percent of the monthly premiums paid by members.

Guidance released by the Biden Adminstration in early 2021 requires insurers to cover COVID-19 testing without member cost-sharing for asymptomatic individuals without requiring medical screenings. Insurers, however, are not required to cover COVID-19 testing without member cost-sharing if it is conducted as part of an employee return to work program. The emergency rule requires health insurers to additionally waive member cost-sharing for all claims for polymerase chain reaction (PCR) tests as well as combined flu and COVID-19 tests. Since insurers are required to cover

most COVID-19 testing without member cost-sharing by the federal government, it is unlikely that the emergency rule will impose any significant additional costs.

With respect to claims for COVID-19 treatment, the Department found that Vermont insurers have each spent less than $2 million from the beginning of the pandemic to June 1, 2021. In its plan year 2022 individual rate filing, Blue Cross Blue Shield of Vermont stated that any increased costs in 2021 and 2022 due explicity to the COVID-19 pandemic will be funded through policyholder reserves. Because Blue Cross Blue Shield of Vermont and MVP Health Care both expect to be within their mandated risk-based capital (RBC) range by the end of 2022, the Department does not expect the consumer protections in this rule to materially impact insurer reserves or member premiums.

4. IMPACT ON SCHOOLS:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

The Department does not anticipate that the emergency rule will have an impact on schools.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

Because the Department does not anticipate that the emergency rule will have an impact on schools, no alternatives were conisidered to reduce or ameliorate costs to local school districts while still achieving the objective of the rule.

6. IMPACT ON SMALL BUSINESSES:
INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

None.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

Only health insurers are required to comply with the emergency rule; these entities are not small businesses.

8. COMPARISON:

COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:

The Department considered letting emergency rule H-2020-06-E expire completely and only requiring insurers to cover COVID-19 treatment without member cost-sharing for members who are not eligible to receive an FDA authorized COVID-19 vaccine. Neither option, however, would reflect that COVID-19 infections are not entirely preventable. As of April 30, 2021, a total of 10,262 SARS-CoV-2 vaccine "breakthrough" infections had been reported from 46 U.S. states and territories, including 225 cases in Vermont. Without the emergency rule, consumer protections to ensure access to health care for these individuals would expire, with potentially devastating financial consequences.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ECONOMIC IMPACT ANALYSIS.*

In light of the Department's continuing response to COVID-19, the analysis described herein is sufficent to enact the emergency rule. The cost of the substantive changes are minimal or a net positive to Vermonters.

Administrative Procedures – Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

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1. TITLE OF RULE FILING:

   Access to Health Care Services Related to COVID-19

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*

   None.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*

   None.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*

   None.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*

   None.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*

   None.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   None.

9. SUFFICIENCY: *EXPLAIN THE SUFFICIENCY OF THIS ENVIRONMENTAL IMPACT ANALYSIS.*
   The emergency rule is not expected to have any environmental impacts. Therefore, this analysis is sufficent.

Administrative Procedures – Public Input

Instructions:

In completing the public input statement, an agency describes the strategy prescribed by ICAR to maximize public input, what it did do, or will do to comply with that plan to maximize the involvement of the public in the development of the rule.

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:
   Access to Health Care Services Related to COVID-19
2. ADOPTING AGENCY:
   Department of Financial Regulation
3. PLEASE DESCRIBE THE STRATEGY PRESCRIBED BY ICAR TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE:
   In drafting the emergency rule, the Department solicited input from a broad array of stakeholders, including the Bi-State Primary Care Association, Vermont Care Partners, Vermont Medical Society, Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Office of the Health Care Advocate, Vermont Care Partners, Vermont Assocation of Adult Day Centers, Blue Cross Blue Shield of Vermont, MVP Health Care, Cigna, and Aetna. The Department also had follow-up meetings with Blue Cross Blue Shield of Vermont prior to filing the emergency rule.
4. PLEASE LIST THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:
   Because the emergency rule represents a repeal and reissue of the Department's previously adopted emergency rule, the Department solicited comment from stakeholders on the merits of extending consumer protections related to COVID-19 to 03/31/2022. The emergency rule will also be posted on the Department's website.
   As with previous emergency rules issued in response to the COVID-19 pandemic, the Department will ensure the

availiabity of materials relating to this rule online and in paper form, and work with stakeholders to educate members of the public.

5. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Bi-State Primary Care Association, Vermont Care Partners, Vermont Medical Society, Vermont Association of Hospitals and Health Systems, VNAs of Vermont, Office of the Health Care Advocate, Vermont Care Partners, Vermont Assocation of Adult Day Centers, Blue Cross Blue Shield of Vermont, MVP Health Care, Cigna, and Aetna.

Administrative Procedures – Incorporation by Reference

THIS FORM IS ONLY REQUIRED WHEN INCORPORATING MATERIALS BY REFERENCE. PLEASE REMOVE PRIOR TO DELIVERY IF IT DOES NOT APPLY TO THIS RULE FILING:

Instructions:

In completing the incorporation by reference statement, an agency describes any materials that are incorporated into the rule by reference and how to obtain copies.

This form is only required when a rule incorporates materials by referencing another source without reproducing the text within the rule itself (e.g. federal or national standards, or regulations).

Incorporated materials will be maintained and available for inspection by the Agency.

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1. TITLE OF RULE FILING:

   Access to Health Care Services Related to COVID-19

2. ADOPTING AGENCY:

   Department of Financial Regulation

3. DESCRIPTION (*DESCRIBE THE MATERIALS INCORPORATED BY REFERENCE)*:

   This rule incorporates the following laws and regulations of the United States and the State of Vermont: Title 18 V.S.A., section 9402.

4. FORMAL CITATION OF MATERIALS INCORPORATED BY REFERENCE: 18 V.S.A. § 9402.

5. OBTAINING COPIES: *EXPLAIN WHERE THE PUBLIC MAY OBTAIN THE MATERIAL(S) IN WRITTEN OR ELECTRONIC FORM, AND AT WHAT COST)*:

   All of the cited materials are available online at the following links:

   Vermont Statutes Annotated:

   https://legislature.vermont.gov/statutes/

   Although all cited materials are readily available online, members of the public may obtain printed copies by contacting the Department by phone at 802-828-3301.

6. MODIFICATIONS (*PLEASE EXPLAIN ANY MODIFICATION TO THE INCORPORATED MATERIALS E.G., WHETHER ONLY PART OF THE MATERIAL IS ADOPTED AND IF SO, WHICH PART(S)ARE MODIFIED)*:

No modifications have been made to the cited material.

Run Spell Check

Questions On Charges For The Uninsured

Q1: Can a hospital waive collection of charges to an indigent, uninsured individual?

A1: Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.

In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Q2: What if a hospital wants to discount charges to patients with large medical bills?

A2: In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies. The separate issue of how Medicare reimburses for the uncollectible deductibles and coinsurance of Medicare beneficiaries will be discussed in answers below.
The OIG advises that discounts to underinsured patients can raise concerns under the Federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other Federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG webpage.

Q3: Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A3: No, a hospital does not need permission before offering discounts. However, the

Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

Q4: Does offering discounts to the uninsured/underinsured affect a hospital's cost to charge ratio or Medicare cost apportionment?

A4: No, as long as the provider properly reports full charges on the Medicare cost report. This is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system.

Q5: How is the above any different than a hospital giving a discount to Blue Cross or any other insurer?

A5: For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances. The Medicare program sees no complications where a provider offers discounts or allowances to uninsured or underinsured patients versus allowing discounts or allowances to third-party payers.

Q6: Does the Medicare program's lesser of costs or charges (LCC) principle alter any of the above advice or prohibit hospitals from offering discounts to the uninsured or the underinsured?

A6: The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced.

The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But the vast majority of services provided in hospitals in America today are not subject to the LCC principle.

In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC. And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Q7: Will Medicare pay a hospital's bad debts for non-Medicare patients who don't pay their bills?

A7: No. Medicare does not pay the bad debts of non-Medicare patients.

Q8: Does Medicare provide any special compensation to hospitals that treat a large number of uninsured patients – especially those hospitals that have to write off a large number of bills for the uninsured?

A8: Yes. CMS makes payments – significant payments – to hospitals that treat a large number of low-income and uninsured patients. For example, the Medicare and Medicaid disproportionate share provisions paid $22 billion to hospitals last year. And under the rules we explain in Question 9, Medicare pays over $1 billion per year to hospitals for the bad debts of Medicare patients.

Q9: Can a hospital be reimbursed by Medicare for a Medicare patient's unpaid deductibles or coinsurance? Are there special rules for this "bad debt" if the patient meets the hospital's indigency guidelines?

A9: Yes. In the case of Medicare patients generally, the program reimburses a hospital for a percentage of the "bad debt" of a Medicare beneficiary (i.e., unpaid deductibles or coinsurance) as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts.
However, if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent (as we used that term in question 1), the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts. Hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to their income). In the case of a Medicare patient that is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance.

Q10: Can a hospital determine its own individual indigency criteria?

A10: Yes. It must, however, apply the criteria to Medicare and non-Medicare patients uniformly.

Q11: Does CMS have any requirements as to what documentation a hospital must secure in order to make an indigency determination? If so, what are those requirements?

A11: For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

Q12: Are hospitals required to take low-income patients to court, or seize their homes, or send claims out to a collection agency when those patients don't pay their hospital bills?

A12: No. Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients.
However, as we noted and explained more fully above in question 9, the Medicare program does contain a special feature that allows a hospital to be paid for its Medicare bad debts. If a hospital wants this special reimbursement adjustment, it must, at the very least, send the Medicare patient a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Q13: Can a hospital write off a Medicare patient's bill but take aggressive collection action against a non-Medicare patient who doesn't pay his/her bill?

A13: Again, this is a decision to be made by the hospital. If a hospital decides that it wants the special Medicare reimbursement allowing for payment of Medicare bad debts, however, then it must engage in uniform collection efforts for all patients, both Medicare and non-Medicare.

Q14: Can a hospital be subject to criminal sanctions or penalties if it writes off a patient's bill?

A14: As explained more fully on its webpage, the OIG advises that offering a discount to an uninsured patient will not implicate the Federal anti-kickback statute, so long as the discount is not linked in any way to referrals of Federal health care program business.

Q15: What if the hospital wants to write off a Medicare patient's deductible and coinsurance regardless of their income level? Is that permissible?

A15: Yes. If a hospital does not want to collect, but wants to write off the uncollected debt regardless of income level, as "charity care" or as a "courtesy allowance," Medicare rules don't prohibit that, but Medicare will also not reimburse these amounts. Furthermore, a hospital may also forgo collection of deductible and coinsurance amounts using its customary methods for determining indigency, according to the bad debt policy stated in the Provider Reimbursement Manual. Bad debt reimbursement policies are governed by Medicare, but, as we note in the answers to Questions 12 and 13, these apply only where a hospital which has unpaid Medicare coinsurance and deductibles wants Medicare reimbursement for them.

Moreover, as explained in detail on its webpage, the OIG advises that under the Federal anti-kickback statute, there is an available safe harbor for waivers of Part A deductible and coinsurance amounts without regard to financial need. In addition, hospitals have the ability to provide relief to Medicare beneficiaries who cannot afford to pay their hospital bills by waiving all or part of a Medicare cost-sharing amount, so long as the waiver is not advertised, not routine, and made after there has been a good faith, individualized determination of financial need or failure of reasonable collection efforts. Advertised cost-sharing waivers, routine waivers, or waivers not based on good faith, individualized determinations of financial need or failed collection efforts potentially implicate both the anti-kickback statute and the civil monetary penalties provision barring the offering of inducements to Medicare and Medicaid beneficiaries.

Q16: What steps can hospitals take to assist the uninsured? The underinsured?

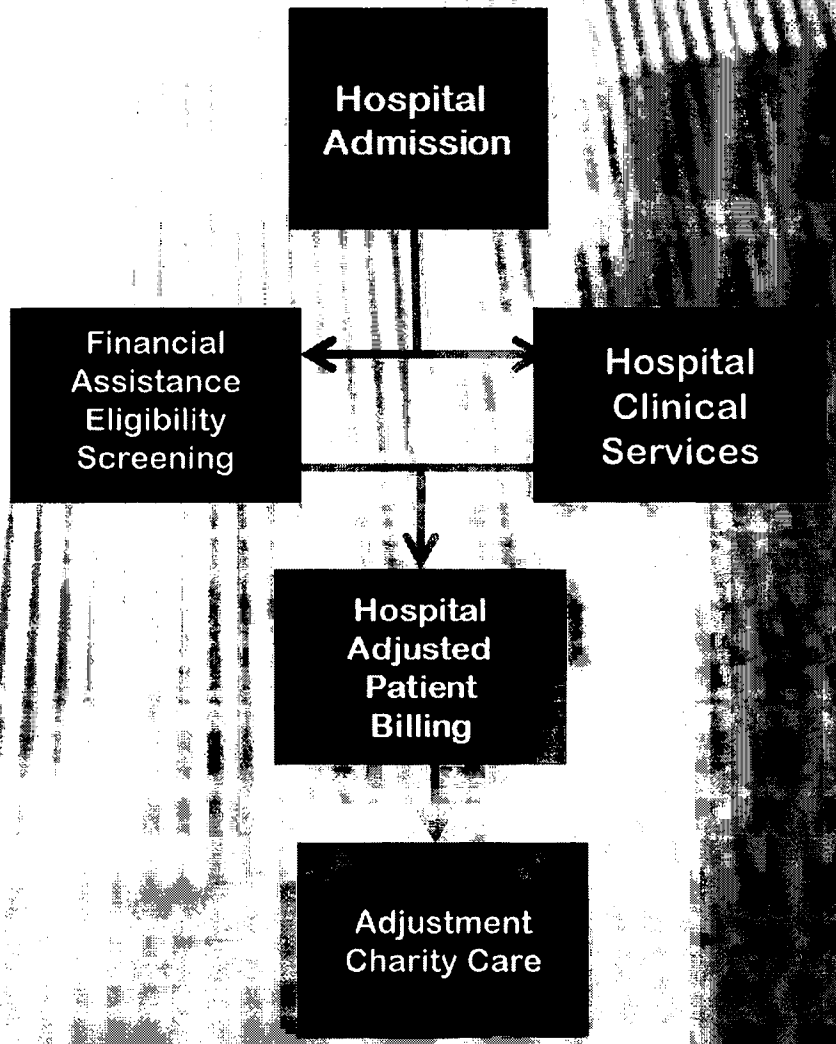
A16: The Department of Health and Human Services notes with interest the many steps that state hospital associations such as the Hospital Association of New York State and the Florida Hospital Association, and community hospitals across the country, have taken recently to address the issue of charges to the indigent and medically indigent. As these hospitals have already discovered, they can take several steps to assist patients with payment for hospital care. For example, hospitals can ensure that all written policies for assisting low-income patients are applied consistently. In addition, hospitals can review their current charge structures and ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. Finally, hospitals could also implement written policies about when and under whose authority patient debt is advanced for collection. For example, a hospital could decide that only the CEO of the hospital can authorize collection action for a patient debt. As we have noted, this is a

decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement for Medicare bad debts.

Financial Assistance Eligibility Screening Hospital Flow Chart

- Hospital admissions captures patient demographics and transmits to credit expert
- Decisioning: credit expert determines patient's "financial ability to pay" transmits to hospital
- Hospital adjusts patient's billing
- Financial counselor has positive discussion with patient concerning adjusted billing

Decisioning can be accomplished by numerous independent third party vendors.



News Release

FOR IMMEDIATE RELEASE
Thursday, Feb. 19, 2004

Contact: HHS Press Office
(202) 690-6343

Text of Letter From Tommy G. Thompson Secretary of Health and Human Services To Richard J. Davidson, President, American Hospital Association

Richard J. Davidson
President
American Hospital Association
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802

Dear Mr. Davidson:

I received your letter regarding the issue of hospitals charging uninsured Americans more than individuals who have health insurance coverage. Hospitals' charging the uninsured the highest rates is a serious issue that demands all of our attention.

As I am sure you are aware, Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals provisions to help hospitals bear the cost of caring for the poor and uninsured. In addition, although Medicare beneficiaries are not uninsured, Medicare pays hospitals approximately $1 billion a year to compensate them for bad debt associated with serving Medicare clients.

Your letter suggests that HHS regulations require hospitals to bill all patients using the same schedule of charges and suggests that as a result, the uninsured are forced to pay "full price" for their care. That suggestion is not correct and certainly does not accurately reflect my policy. The advice you have been given regarding this issue is not consistent with my understanding of Medicare's billing rules. To be sure that there will be no further confusion on this matter, at my direction, the Centers for Medicare & Medicaid Services and the Office of Inspector General have prepared summaries of our policy that hospitals can use to assist the uninsured and underinsured. This guidance shows that hospitals can provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the Medicare program rules or regulations prohibit such discounts. In addition, the Office of Inspector General informs me that hospitals have the ability to offer discounts to uninsured and underinsured individuals and cost-sharing waivers to financially needy Medicare beneficiaries.

With this guidance as a tool, I strongly encourage you to work with AHA member hospitals to take action to assist the uninsured and underinsured and therefore, end the situation where, as you said in your own words, "uninsured Americans and others of limited means are often billed and required to pay higher charges."

Sincerely,

/s/

Tommy G. Thompson

Questions and answers are available at http://www.cms.hhs.gov/FAQ_Uninsured.pdf.

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Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

Last Revised: February 20, 2004

United States Senate Committee on Finance

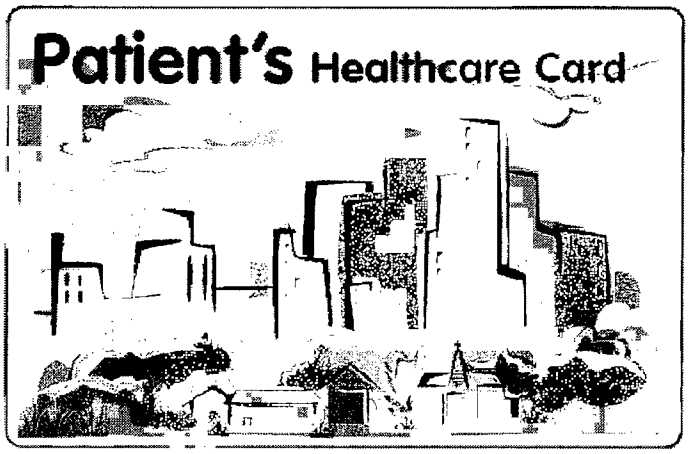
Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals

September 13, 2006, at 10:00 a.m., in 215 Dirksen Senate Office Building

STATEMENT OF ALLIANCE NATIONAL, INC.

1063 Snowdon Court, Asheboro, NC 27203-4055

VIEWS OF ROGER BERLINER, CEO



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rogerberliner@patientshealthcarecard.com

United States Senate Committee on Finance

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STATEMENT OF ALLIANCE NATIONAL, INC.

1063 Snowdon Court, Asheboro, NC 27203-4055

VIEWS OF ROGER BERLINER, CEO

Thank you for the opportunity to provide testimony for the record of the Senate Finance Committee's September 13, 2006 hearing on charitable care and community benefits at non-profit hospitals.

Alliance National, Inc. (ANI) is a financial services company that is engaged in the development of proprietary products to manage, service and fund the out-of-pocket portion of health care. We apply contemporary risk management techniques and operating systems to create products that allow providers to make objective, replicable decisions as to which accounts are payable, in whole or part, and which should be expensed as charitable care, courtesy allowances or bad debt. The techniques utilized are a patent-pending intellectual property that is available for licensing.

Among other things, our approach creates an auditable record of why an allocation was made to a specific category. This would allow IRS, Medicare, state Medicaid agencies and payers to determine whether applicable federal, state and community standards were consistently achieved. In particular, as it relates to the Senate Finance Committee's concerns, IRS would be able to determine in an efficient manner whether a charge is being improperly categorized.

While not the topic of the committee's hearing, we note that this capacity to manage the out-of-pocket portion of health care costs using objective standards also has applicability in reducing the number of uninsured individuals in the United States. We are preparing for field testing of the Patient's Healthcare Card[SM] program with BlueCross & BlueShield of Florida. One goal of our joint effort is the development of cost-effective insurance products for employers that currently do not provide health insurance for their employees and for individuals of limited means without health insurance. To make these products work, payers and providers need a system that tracks deductibles and co-payments in real-time.

ANI's Objective Response to Medicare's Subjective Standards on Ability to Pay

As the Finance Committee is discovering, properly accounting for charitable care, courtesy allowances and bad debt is close to impossible under the current system. Even providers with the purest of motives cannot be sure that they have fulfilled the requirements of law.

Providers have been held to standards that have no objective basis. Every non-paying patient forces decisions that cannot be assured in advance to be correct nor with any certainty determined to be correct afterward (audit trail). In contrast, providers using ANI programs are able to assure themselves that they have met all applicable rules and requirements and know that they will have a clean audit as it relates to allocation of expenses to charitable care, courtesy allowances or bad debt.

ANI's system of objective, replicable standards for ability to pay, directly responds to the lack of usable guidance provided by CMS. In a 2004 exchange of letters between the American Hospital Association and the US Department of Health and Human Services, the Secretary stated "Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patient, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy."

In the six page Q&A, the Secretary provided extensive detail on various nuances of the Department's position, particularly that income thresholds and collections procedures must be the same for Medicare and non-Medicare patients. Waiving collection of charges is clearly permitted in the Secretary's six page Q&A. However, as the AHA pointed out, there is no guidance as to what basis should be used in developing a policy to determine a patient's financial ability to pay for services and when and how it should be applied.

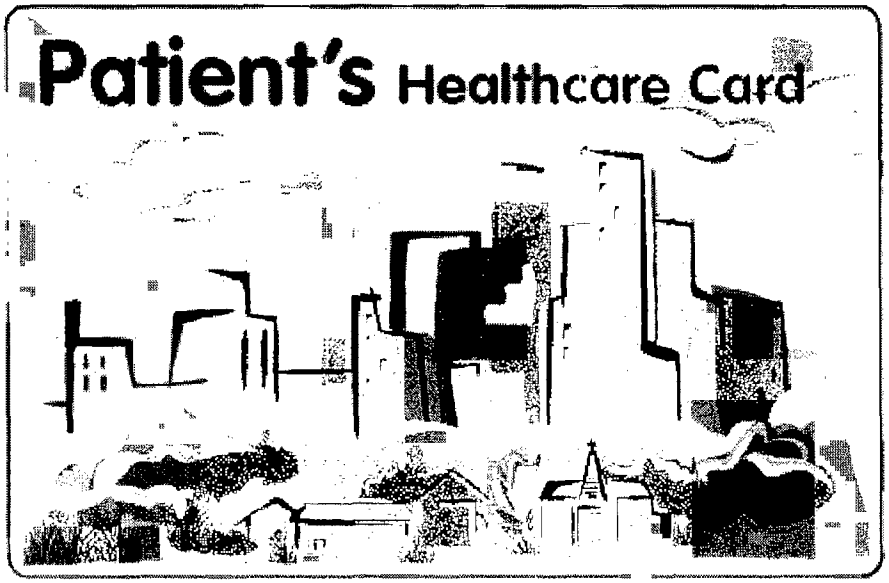
This is not quite true. The Provider Reimbursement Manual and Program Instructions that were put in place in 1974 sets standards by use of terms such as "best business judgment" and others. This effectively established subjective analysis as guidance and standard.

From a provider's standpoint, the goal is to have a set of objective standards on ability to pay that can be replicated in consistent fashion regardless of the patient's financial situation or insurance coverage. It is this capability that ANI brings to the marketplace. With its use, providers can know in advance that they are treating all patients fairly with regard to ability to pay and that, in doing so, they are also producing auditable protocols that assure them of legal compliance with regard to charitable care, courtesy allowances and bad debt.

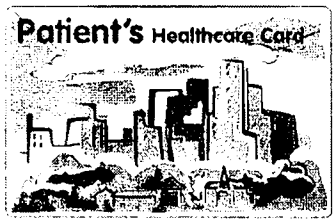
Conclusion: Problems with Charity Care and Bad Debt are Solvable

Providers, as well as any debt collection agency that they hire, lack an objective measure of ability to pay that can be fairly applied to all patients. Regulations lead providers astray by telling them to use their "best business judgment," as if credit assessment is or should be a core competency of providers.

ANI would be pleased to have the opportunity to provide the Finance Committee with additional information on solutions that provide objective standards and auditable results.



Have we really done what is in the best interest of the patient, if we heal them medically, but we break them financially?

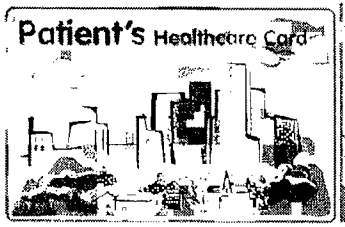


The Healthcare Card

All of your patient-pay on Your credit card

The Healthcare Card

- ✓ improve receipt of patient-pay through expert management
- ✓ reduce the cost of monthly billing of patient-pay
- ✓ accomplish compliance with government reporting requirements for charitable care, courtesy allowances and bad debt



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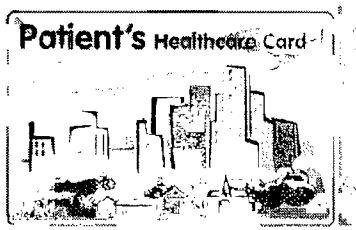
- The Healthcare Card program is a healthcare-centric, community-based system for providing objective and efficient management of patient-pay.
- The Healthcare Card program improves provider-patient relations.
- The Healthcare Card program automatically enrolls all patients.
- The Healthcare Card program enrolls existing patient-pay receivables.
- The Healthcare Card program is a national shared service initiative, supporting physicians, hospitals, and other members of the health care community.
- The Healthcare Card program offers improved performance of patient-pay assets, through expert management.

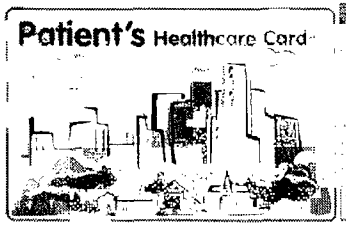


- Reports via secure proprietary internet access provide information daily of patient account activity at corporate and/or individual participant level.

- The Healthcare Card program is flexible: if a patient incurs additional charges or insurance pays more (or less), the balance due is automatically adjusted or additional credit is extended to the patient.

- There are no budgetary constraints, no initial out-of-pocket expenses in becoming a participant in the program.

- The Healthcare Card program is a revolving credit program of all patients



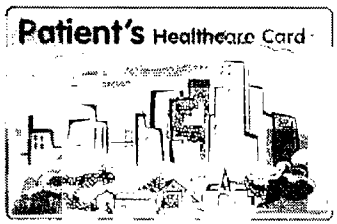
Val

Provider:

- Accomplishable implementation
- Provider created singular discrete account for each patient
- Effective and efficient management of patient-pay
- Increased income, reduced cost

Patient:

- Internet account access – payments, statements, etc.
- Single statement billing
- Single payment – responsible party
- Complete record of out-of-pocket expenses
  - Co-payment
  - Deductibles

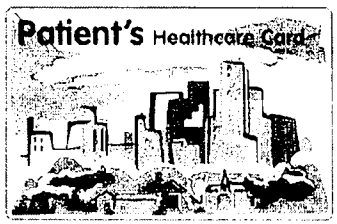


The Healthcare Card program can effectively and efficiently accomplish all requisite documentation required for proper accounting of courtesy allowances, charity care and bad debt. The Healthcare Card will make inquiry on behalf of a provider and indemnify the provider against fraud or abuse with respect to indigent, uninsured and underinsured patients whose accounts are managed and serviced in the program.

Using an objective risk based tool for assessing a patient's ability to pay, the program meets the requirements for uniformity necessary to receive "the special Medicare reimbursement allowance for payment of Medicare bad debts."

Additionally, litigation for unfair biling practices would be all but eliminated.

- ✓ an estimated 100% improvement in the receipt rate of patient-pay
- ✓ reduced operating expenses – economy of scale
- ✓ improved patient relations – all patients evaluated using the same tool, eliminating potential litigation for unfair billing practices
- ✓ compliance with government accounting requirements for charitable care, courtesy allowances and bad debt
- ✓ elimination of the hostile, threatening and intimidating environment associated with patient-pay



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HOSPITAL DISCOUNTS OFFERED TO PATIENTS WHO CANNOT AFFORD TO PAY THEIR HOSPITAL BILLS

This document addresses the views of the Office of Inspector General ("OIG") on the following topics: (1) discounts provided by hospitals for uninsured patients who cannot afford to pay their hospital bills and (2) reductions or waivers of Medicare cost-sharing amounts by hospitals for patients experiencing financial hardship. For the following reasons, the OIG believes that hospitals have the ability to provide relief to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing amounts. The OIG fully supports hospitals' efforts in this area.

Discounts for Uninsured Patients Who Cannot Afford to Pay Their Hospital Bills

No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. It has been suggested that two laws enforced by the OIG may prevent hospitals from offering discounted prices to uninsured patients. We disagree and address each law in turn.

- **The Federal Anti-Kickback Statute.**[1] The Federal anti-kickback statute prohibits a hospital from giving or receiving anything of value in exchange for referrals of business payable by a Federal health care program, such as Medicare or Medicaid. The Federal anti-kickback statute does not prohibit discounts to uninsured patients who are unable to pay their hospital bills. However, the discounts may not be linked in any manner to the generation of business payable by a Federal health care program. Discounts offered to underinsured patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. As discussed below, the statute and regulations offer means to reduce or waive coinsurance and deductible amounts to provide assistance to underinsured patients with reasonably verified financial need.

- **Section 1128(b)(6)(A) of the Social Security Act.**[2] This law permits – but does not require – the OIG to exclude from participation in the Federal health care

[1] 42 U.S.C. § 1320a-7b(b).

[2] 42 U.S.C. § 1320a-7(b)(6)(A).

programs any provider or supplier that submits bills or requests for payment to Medicare or Medicaid for amounts that are substantially more than the provider's or supplier's usual charges. The statute contains an exception for any situation in which the Secretary finds "good cause" for the substantial difference. The statute is intended to protect the Medicare and Medicaid programs – and taxpayers – from providers and suppliers that routinely charge the programs substantially more than their other customers.

The OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[3] Among other things, the proposed regulations would make clear that free or substantially reduced charges to uninsured persons would not affect the calculation of a provider's or supplier's "usual" charges, as the term "usual charges" is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that, when calculating their "usual charges" for purposes of section 1128(b)(6)(A), individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.

As noted in the preamble to the proposed regulations, the exclusion provision does not require a hospital to charge everyone the same price; nor does it require a hospital to offer Medicare or Medicaid its "best price." However, hospitals cannot routinely charge Medicare or Medicaid substantially more than they usually charge others.

In addition to the two laws discussed above, it has been suggested that hospitals are reluctant to give discounts to uninsured patients because the OIG requires hospitals to engage in vigorous collection efforts against uninsured patients. This misperception may be based on some limited OIG audits of specific hospitals' compliance with Medicare's bad debt rules. The bad debt rules and regulations, including the scope of required collection efforts, are established by the Centers for Medicare & Medicaid Services ("CMS"). No OIG rule or regulation requires a hospital to engage in any particular collection practices.

[3] 68 Fed. Reg. 53939 (Sept. 15, 2003).

Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship

The fraud and abuse laws clearly permit the waiver of all or a portion of a Medicare cost-sharing amount for a financially needy beneficiary.[4] Importantly, under the fraud and abuse laws, the "financial need" criterion is not limited to "indigence," but can include any reasonable measures of financial hardship.

Like many private insurance plans, the Medicare program includes a cost-sharing requirement. Cost-sharing is an important control on overutilization of items and services. If beneficiaries are required to pay for a portion of their care, they will be better health care consumers, selecting items or services because they are medically needed.

The routine waiver of Medicare coinsurance and deductibles can violate the Federal anti-kickback statute (discussed above) if one purpose of the waiver is to generate business payable by a Federal health care program.[5] In addition, a separate statutory provision prohibits offering inducements – including cost-sharing waivers – to a Medicare or Medicaid beneficiary that the offeror knows or should know are likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier.[6] (This prohibition against inducements offered to Medicare and Medicaid beneficiaries does not apply to uninsured patients.)

However, there are two important exceptions to the general prohibition against waiving Medicare coinsurance and deductibles applicable to hospitals, one for financial hardship situations and one for inpatient hospital services.

First, providers, practitioners, and suppliers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived so long as:

- the waiver is not offered as part of any advertisement or solicitation;

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[4]Hospitals still need to ensure that they comply with all relevant Medicare program rules.

[5]In certain circumstances, the routine waiver of coinsurance and deductible amounts can implicate the False Claims Act, 31 U.S.C. § 3729. See Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994), available on the OIG webpage at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.

[6]42 U.S.C. § 1320a-7a(a)(5). The statute includes several other exceptions. One exception permits the waiver of cost-sharing amounts for certain preventive care services without any requirement to determine financial need. 42 U.S.C. § 1320a-7a(i)(6)(D); 42 C.F.R. § 1003.101; see also 65 Fed. Reg. 24400, 24409 (April 26, 2000).

- the party offering the waiver does not routinely waive coinsurance or deductible amounts; and

- the party waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.[7]

The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- the local cost of living;
- a patient's income, assets, and expenses;
- a patient's family size; and
- the scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

Second, another exception to the general prohibition against Medicare cost-sharing waivers is contained in an OIG "safe harbor" regulation related to inpatient hospital services.[8] Compliance with a safe harbor regulation is voluntary, and failure to comply does not necessarily mean an arrangement is illegal. However, a hospital that complies fully with a safe harbor is assured that it will not be prosecuted under the Federal anti-kickback statute.[9]

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[7]42 U.S.C. § 1320a-7a(i)(6)(A); Special Fraud Alert, supra note 5.

[8]42 C.F.R. § 1001.952(k).

[9]Furthermore, 42 U.S.C. § 1320a-7a(i)(6)(B) provides that any waiver that fits in a safe harbor to the anti-kickback statute is similarly protected under the beneficiary inducements statute (discussed above).

The safe harbor for waivers of coinsurance and deductibles provides that a hospital may waive coinsurance and deductible amounts for inpatient hospital services for which Medicare pays under the prospective payment system if the hospital meets three conditions:

- the hospital cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other payers, or individuals;
- the waiver must be made without regard to the reason for admission, length of stay, or diagnostic related group; and
- the waiver may not be part of a price reduction agreement between the hospital and a third-party payer (other than a Medicare SELECT plan).

While the OIG is not concerned about bona fide cost-sharing waivers for beneficiaries with genuine financial need, we have a long-standing concern about providers and suppliers that use "insurance only billing" and similar schemes to entice Federal health care program beneficiaries to obtain items or services that may be medically unnecessary, overpriced, or of poor quality.

OIG Advisory Opinion Process

The OIG has an advisory opinion process that is available to hospitals or others that want assurance that they will not run afoul of the fraud and abuse laws.[10] OIG advisory opinions are written opinions that are legally binding on the OIG, the Department of Health and Human Services, and the party that requests the opinion. To obtain an opinion, the requesting party must submit a detailed, written description of its existing or proposed business arrangement. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. Further information about the process, including frequently asked questions, can be found on the OIG webpage at http://oig.hhs.gov/fraud/advisoryopinions.html.

[10]Section 1128D(b) of the Social Security Act; 42 C.F.R. part 1008.

Conclusion

Hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in the OIG rules or regulations prohibits such discounts, and the OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. While every case must be evaluated on its own merits, it is important to note that the OIG has never brought a case based on a hospital's bona fide discounting of its bill for an uninsured or underinsured patient of limited means.

Guidance about the anti-kickback statute and other fraud and abuse authorities is available on the OIG's webpage at http://oig.hhs.gov/. This guidance includes the Special Fraud Alert on Routine Waivers of Copayments and Deductibles under Medicare Part B; safe harbor regulations (and the "preamble" discussions that include explanatory information), the compliance program guidance for hospitals, and OIG advisory opinions.

February 2, 2004

Clean Text

VERMONT DEPARTMENT OF FINANCIAL REGULATION

EMERGENCY RULE H-2021-01-E

ACCESS TO HEALTH CARE SERVICES RELATED TO COVID-19

Section 1. Background and Purpose.

(a) This emergency rule is adopted under Act 6 of 2021.

(b) This emergency rule rescinds and supersedes the provisions of Rule H-2020-06-E.

(c) The purpose of this emergency rule is to expand health insurance coverage for and waive or limit certain cost-sharing requirements directly related to, COVID-19 diagnosis, treatment, and prevention.

Section 2. Definitions.

Terms used in this emergency rule shall have the meanings given to such terms, if any, in 18 V.S.A. § 9402.

Section 3. Coverage of COVID-19 Diagnosis, Treatment, and Prevention.

(a) Coverage of COVID-19 (SARS-CoV-2) Testing. Health insurers shall process all claims for FDA-authorized SARS-CoV-2 testing with the following procedure codes without member cost-sharing:

(1) Tests: U0001, U0002, U0003, U0004, 87635; and

(2) Specimen collection: G2023, G2024.

(b) Coverage of Testing for Influenza, Pneumonia, or Other Respiratory Illness Performed in Connection with Making a COVID-19 Diagnosis.

(1) Health insurers shall process all claims for FDA-authorized combined influenza and SARS-CoV-2 testing with procedure codes 87636, 87637, 0240U, and 0241U without member cost-sharing;

(2) Consistent with section 6001(a) of the Families First Coronavirus Response Act (FFCRA), health insurers shall process all medically necessary claims for other testing for influenza, pneumonia, or respiratory illness related to the furnishing or administration of COVID-19 diagnostic testing without member cost-sharing.

(c) Services Associated with COVID-19 Testing. Consistent with section 6001(a)(2) of the FFCRA, Health insurers shall process items and services related to the furnishing or administration of COVID-19 diagnostic testing, including facility fees, without member cost-sharing when one of the following diagnosis codes is the primary diagnosis on the claim:

(1) U07.1: Confirmed COVID-19 diagnosis;

(2) Z20.822: Contact with and (suspected) exposure to COVID-19; Contact with and (suspected) exposure to SARSCoV-2.

(d) Administration. Health insurers shall establish appropriate contractual, billing, and other administrative arrangements to reimburse providers for the cost of collecting specimens and conducting testing.

(e) Coverage of COVID-19 Treatment. Health insurers shall process all claims for the following services without member cost-sharing:

(1) medically necessary COVID-19 treatment, whether delivered in an inpatient or outpatient setting;

(2) medication administered or prescribed in connection with medically necessary COVID-19 treatment as described in paragraph (1) of this subsection; and

(3) emergency and nonemergency ambulance transport of members diagnosed with or suspected of having COVID-19 to and from recovery or isolation areas.

(f) Coverage of COVID-19 Prevention. Consistent with section 4203 of the Coronavirus Aid, Relief, and Economic Security Act, health insurers shall cover any qualifying coronavirus preventive service without member cost-sharing.

(g) Out-of-Network Services. Consistent with § 5.1(K)(2) of Department Rule H-2009-03, health insurers shall cover out-of-network services described in subsections (a), (b), (c), (e), and (f) of this section without member cost-sharing. The liability of a health insurer to a non-contracted provider for services rendered to a member under this subsection shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the health insurer to respond to, defend against, and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the under this subsection. There shall be no additional liability to the member.

Section 4. Severability.

If any provision of this emergency rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall be not affected thereby.

Section 5. Conflict with Federal Law.

Nothing in this emergency rule is intended to or should be construed to be in conflict with federal law.

Section 6. Effective Dates.

This emergency rule shall become effective on adoption and, pursuant to the authority granted in Act 6 of 2021 (§ 8), shall remain in effect until March 31, 2022.

No. 6. An act relating to extending health care regulatory flexibility during and after the COVID-19 pandemic and to coverage of health care services delivered by audio-only telephone.

(S.117)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 2020 Acts and Resolves No. 91, as amended by 2020 Acts and Resolves No. 140, Sec. 13, is further amended to read:

* * * Supporting Health Care and Human Service Provider Sustainability * * *

Sec. 1. AGENCY OF HUMAN SERVICES; HEALTH CARE AND HUMAN SERVICE PROVIDER SUSTAINABILITY

Through March 31, ~~2021~~ 2022, the Agency of Human Services shall consider modifying existing rules or adopting emergency rules to protect access to health care services, long-term services and supports, and other human services under the Agency's jurisdiction. In modifying or adopting rules, the Agency shall consider the importance of the financial viability of providers that rely on funding from the State, federal government, or Medicaid, or a combination of these, for a major portion of their revenue.

* * *

* * * Protections for Employees of Health Care Facilities and Human Service Providers * * *

Sec. 3. PROTECTIONS FOR EMPLOYEES OF HEALTH CARE FACILITIES AND HUMAN SERVICE PROVIDERS

In order to protect employees of a health care facility or human service

provider who are not licensed health care professionals from the risks associated with COVID-19, through March 31, ~~2021~~ 2022, all health care facilities and human service providers in Vermont, including hospitals, federally qualified health centers, rural health clinics, residential treatment programs, homeless shelters, home- and community-based service providers, and long-term care facilities, shall follow guidance from the Vermont Department of Health regarding measures to address employee safety, to the extent feasible.

* * * Compliance Flexibility * * *

Sec. 4. HEALTH CARE AND HUMAN SERVICE PROVIDER REGULATION; WAIVER OR VARIANCE PERMITTED

Notwithstanding any provision of the Agency of Human Services' administrative rules or standards to the contrary, through March 31, ~~2021~~ 2022, the Secretary of Human Services may waive or permit variances from the following State rules and standards governing providers of health care services and human services as necessary to prioritize and maximize direct patient care, support children and families who receive benefits and services through the Department for Children and Families, and allow for continuation of operations with a reduced workforce and with flexible staffing arrangements that are responsive to evolving needs, to the extent such waivers or variances are permitted under federal law:

(1) Hospital Licensing Rule;

(2) Hospital Reporting Rule;

(3) Nursing Home Licensing and Operating Rule;

(4) Home Health Agency Designation and Operation Regulations;

(5) Residential Care Home Licensing Regulations;

(6) Assisted Living Residence Licensing Regulations;

(7) Home for the Terminally Ill Licensing Regulations;

(8) Standards for Adult Day Services;

(9) Therapeutic Community Residences Licensing Regulations;

(10) Choices for Care High/Highest Manual;

(11) Designated and Specialized Service Agency designation and provider rules;

(12) Child Care Licensing Regulations;

(13) Public Assistance Program Regulations;

(14) Foster Care and Residential Program Regulations; and

(15) other rules and standards for which the Agency of Human Services is the adopting authority under 3 V.S.A. chapter 25.

* * *

Sec. 6. MEDICAID AND HEALTH INSURERS; PROVIDER ENROLLMENT AND CREDENTIALING

~~(a)~~ Until ~~the last to terminate of a declared state of emergency in Vermont as a result of COVID-19, a declared federal public health emergency as a result of COVID-19, and a declared national emergency as a result of COVID-19~~

March 31, 2022, and to the extent permitted under federal law, the Department of Vermont Health Access shall relax provider enrollment requirements for the Medicaid program, and the Department of Financial Regulation shall direct health insurers to relax provider credentialing requirements for health insurance plans, in order to allow for individual health care providers to deliver and be reimbursed for services provided across health care settings as needed to respond to Vermonters' evolving health care needs.

~~(b) In the event that another state of emergency is declared in Vermont as a result of COVID-19 after the termination of the State and federal emergencies, the Departments shall again cause the provider enrollment and credentialing requirements to be relaxed as set forth in subsection (a) of this section.~~

* * *

* * * Access to Health Care Services and Human Services * * *

* * *

Sec. 9. PRESCRIPTION DRUGS; MAINTENANCE MEDICATIONS; EARLY REFILLS

(a) As used in this section, "health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b) Through ~~June 30, 2021~~ March 31, 2022, all health insurance plans and Vermont Medicaid shall allow their members to refill prescriptions for chronic

maintenance medications early to enable the members to maintain a 30-day supply of each prescribed maintenance medication at home.

(c) As used in this section, "maintenance medication" means a prescription drug taken on a regular basis over an extended period of time to treat a chronic or long-term condition. The term does not include a regulated drug, as defined in 18 V.S.A. § 4201.

* * *

Sec. 12. BUPRENORPHINE; PRESCRIPTION RENEWALS

Through March 31, ~~2021~~ 2022, to the extent permitted under federal law, a health care professional authorized to prescribe buprenorphine for treatment of substance use disorder may authorize renewal of a patient's existing buprenorphine prescription without requiring an office visit.

Sec. 13. 24-HOUR FACILITIES AND PROGRAMS; BED-HOLD DAYS

Through March 31, ~~2021~~ 2022, to the extent permitted under federal law, the Agency of Human Services may reimburse Medicaid-funded long-term care facilities and other programs providing 24-hour per day services for their bed-hold days.

* * * Regulation of Professions * * *

* * *

Sec. 17. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; OUT-OF-STATE HEALTH CARE PROFESSIONALS

(a) Notwithstanding any provision of Vermont's professional licensure statutes or rules to the contrary, through March 31, ~~2021~~ 2022, a health care professional, including a mental health professional, who holds a valid license, certificate, or registration to provide health care services in any other U.S. jurisdiction shall be deemed to be licensed, certified, or registered to provide health care services, including mental health services, to a patient located in Vermont using telehealth, as a volunteer member of the Medical Reserve Corps, or as part of the staff of a licensed facility or federally qualified health center, provided the health care professional:

(1) is licensed, certified, or registered in good standing in the other U.S. jurisdiction or jurisdictions in which the health care professional holds a license, certificate, or registration;

(2) is not subject to any professional disciplinary proceedings in any other U.S. jurisdiction; and

(3) is not affirmatively barred from practice in Vermont for reasons of fraud or abuse, patient care, or public safety.

(b) A health care professional who plans to provide health care services in Vermont as a volunteer member of the Medical Reserve Corps or as part of the staff of a licensed facility or federally qualified health center shall submit or have submitted on the individual's behalf the individual's name, contact information, and the location or locations at which the individual will be practicing to:

(1) the Board of Medical Practice for medical doctors, physician assistants, and podiatrists; or

(2) the Office of Professional Regulation for all other health care professions.

(c) A health care professional who delivers health care services in Vermont pursuant to subsection (a) of this section shall be subject to the imputed jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable based on the health care professional's profession, in accordance with Sec. 19 of this act.

(d)(1) This section shall remain in effect through March 31, ~~2021~~ 2022, provided the health care professional remains licensed, certified, or registered in good standing.

(2) The Board of Medical Practice and Office of Professional Regulation shall provide appropriate notice of the March 31, 2022 expiration date of this section to:

(A) health care professionals providing health care services in Vermont under this section;

(B) the Medical Reserve Corps; and

(C) health care facilities and federally qualified health centers at which health care professionals are providing services under this section.

Sec. 18. ~~RETIRED HEALTH CARE PROFESSIONALS~~ INACTIVE LICENSEES; BOARD OF MEDICAL PRACTICE; OFFICE OF PROFESSIONAL REGULATION

(a)(1) Through March 31, ~~2021~~ 2022, a former health care professional, including a mental health professional, ~~who retired~~ whose Vermont license, certificate, or registration became inactive not more than three years earlier ~~with the individual's Vermont license, certificate, or registration~~ and was in good standing at the time it became inactive may provide health care services, including mental health services, to a patient located in Vermont using telehealth, as a volunteer member of the Medical Reserve Corps, or as part of the staff of a licensed facility or federally qualified health center after submitting, or having submitted on the individual's behalf, to the Board of Medical Practice or Office of Professional Regulation, as applicable, the individual's name, contact information, and the location or locations at which the individual will be practicing.

(2) A former health care professional who returns to the Vermont health care workforce pursuant to this subsection shall be subject to the regulatory jurisdiction of the Board of Medical Practice or the Office of Professional Regulation, as applicable.

(3) The Board of Medical Practice and Office of Professional Regulation shall provide appropriate notice of the March 31, 2022 expiration date of this section to:

(A) health care professionals providing health care services under this section;

(B) the Medical Reserve Corps; and

(C) health care facilities and federally qualified health centers at which health care professionals are providing services under this section.

(b) Through March 31, ~~2021~~ 2022, the Board of Medical Practice and the Office of Professional Regulation may permit former health care professionals, including mental health professionals, ~~who retired~~ whose Vermont license, certificate, or registration became inactive more than three but less than 10 years earlier ~~with their Vermont license, certificate, or registration~~ and was in good standing at the time it became inactive to return to the health care workforce on a temporary basis to provide health care services, including mental health services, to patients in Vermont. The Board of Medical Practice and Office of Professional Regulation may issue temporary licenses to these individuals at no charge and may impose limitations on the scope of practice of returning health care professionals as the Board or Office deems appropriate.

* * *

Sec. 20. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY AUTHORITY TO ACT FOR REGULATORY BOARDS

(a)(1) Through March 31, ~~2021~~ 2022, if the Director of Professional Regulation finds that a regulatory body attached to the Office of Professional Regulation by 3 V.S.A. § 122 cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Director may exercise the full powers and authorities of that regulatory body, including disciplinary authority.

(2) Through March 31, ~~2021~~ 2022, if the Executive Director of the Board of Medical Practice finds that the Board cannot reasonably, safely, and expeditiously convene a quorum to transact business, the Executive Director may exercise the full powers and authorities of the Board, including disciplinary authority.

(b) The signature of the Director of the Office of Professional Regulation or of the Executive Director of the Board of Medical Practice shall have the same force and effect as a voted act of their respective boards.

(c)(1) A record of the actions of the Director of the Office of Professional Regulation taken pursuant to the authority granted by this section shall be published conspicuously on the website of the regulatory body on whose behalf the Director took the action.

(2) A record of the actions of the Executive Director of the Board of Medical Practice taken pursuant to the authority granted by this section shall be published conspicuously on the website of the Board of Medical Practice.

Sec. 21. OFFICE OF PROFESSIONAL REGULATION; BOARD OF MEDICAL PRACTICE; EMERGENCY REGULATORY ORDERS

Through March 31, ~~2021~~ 2022, the Director of Professional Regulation and the Commissioner of Health may issue such orders governing regulated professional activities and practices as may be necessary to protect the public health, safety, and welfare. If the Director or Commissioner finds that a professional practice, act, offering, therapy, or procedure by persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated is exploitative, deceptive, or detrimental to the public health, safety, or welfare, or a combination of these, the Director or Commissioner may issue an order to cease and desist from the applicable activity, which, after reasonable efforts to publicize or serve the order on the affected persons, shall be binding upon all persons licensed or required to be licensed by Title 26 of the Vermont Statutes Annotated, and a violation of the order shall subject the person or persons to professional discipline, may be a basis for injunction by the Superior Court, and shall be deemed a violation of 3 V.S.A. § 127.

* * *

* * * Telehealth * * *

* * *

Sec. 26. WAIVER OF CERTAIN TELEHEALTH REQUIREMENTS FOR A LIMITED TIME

(a) Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, through March 31, ~~2021~~ 2022, the following provisions related to the delivery of health care services through telemedicine or by store-and-forward means shall not be required, to the extent their waiver is permitted by federal law:

(1) delivering health care services, including dental services, using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 8 V.S.A. § 4100k(i), as amended by this act, if it is not practicable to use such a connection under the circumstances; and

(2) representing to a patient that the health care services, including dental services, will be delivered using a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 in accordance with 18 V.S.A. § 9361(c), if it is not practicable to use such a connection under the circumstances~~; and~~.

(b)~~(3) obtaining and documenting~~ Notwithstanding any provision of 8 V.S.A. § 4100k or 18 V.S.A. § 9361 to the contrary, until 60 days following a declared state of emergency in Vermont as a result of COVID-19, a health care

provider shall not be required to obtain and document a patient's oral or written informed consent for the use of telemedicine or store-and-forward technology prior to delivering services to the patient in accordance with 18 V.S.A. § 9361(c), if obtaining or documenting such consent, or both, is not practicable under the circumstances.

* * *

Sec. 2. 2020 Acts and Resolves No. 140, Sec. 15 is amended to read:

Sec. 15. BOARD OF MEDICAL PRACTICE; TEMPORARY PROVISIONS; PHYSICIANS, PHYSICIAN ASSISTANTS, AND PODIATRISTS

(a) Notwithstanding any provision of 26 V.S.A. § 1353(11) to the contrary, the Board of Medical Practice or its Executive Director may issue a temporary license through March 31, ~~2021~~ 2022 to an individual who is licensed to practice as a physician, physician assistant, or podiatrist in another jurisdiction, whose license is in good standing, and who is not subject to disciplinary proceedings in any other jurisdiction. The temporary license shall authorize the holder to practice in Vermont until a date not later than April 1, ~~2021~~ 2022, provided the licensee remains in good standing.

(b) Through March 31, ~~2021~~ 2022, the Board of Medical Practice or its Executive Director may waive ~~supervision and scope of practice~~ requirements for physician assistants, including scope of practice requirements and the requirement for documentation of the relationship between a physician

assistant and a physician pursuant to 26 V.S.A. § 1735a. The Board or Executive Director may impose limitations or conditions when granting a waiver under this subsection.

Sec. 2a. 2020 Acts and Resolves No. 178, Sec. 12a is amended to read:

Sec. 12a. SUNSET OF PHARMACIST AUTHORITY TO ORDER OR ADMINISTER SARS-COV TESTS

In Sec. 11, 26 V.S.A. § 2023(b)(2)(A)(x) (clinical pharmacy prescribing; State protocol; SARS-CoV testing) shall be repealed on ~~July 1, 2021~~ March 31, 2022.

Sec. 3. 2020 Acts and Resolves No. 91, Sec. 8, as amended by 2020 Acts and Resolves No. 140, Sec. 13 and 2020 Acts and Resolves No. 159, Sec. 10, is further amended to read:

Sec. 8. ACCESS TO HEALTH CARE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

(a) It is the intent of the General Assembly to increase Vermonters' access to medically necessary health care services during and after a declared state of emergency in Vermont as a result of COVID-19.

(b)(1) Until ~~July 1, 2021~~ April 1, 2022, and notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address the following through ~~June 30, 2021~~ March 31, 2022:

~~(1)~~(A) expanding health insurance coverage for, and waiving or limiting cost-sharing requirements directly related to, the diagnosis of COVID-19, including tests for influenza, pneumonia, and other respiratory viruses performed in connection with making a COVID-19 diagnosis; the treatment of COVID-19 when it is the primary or a secondary diagnosis; and the prevention of COVID-19; and

~~(2)~~(B) modifying or suspending health insurance plan deductible requirements for all prescription drugs, except to the extent that such an action would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223~~; and~~

~~(3) expanding patients' access to and providers' reimbursement for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, and brief telecommunication services~~.

(2) Any rules adopted in accordance with this subsection shall remain in effect until not later than April 1, 2022.

Sec. 4. 8 V.S.A. chapter 107, subchapter 14 is amended to read:

Subchapter 14. ~~Telemedicine~~ Telehealth

* * *

§ 4100l. COVERAGE OF HEALTH CARE SERVICES DELIVERED BY AUDIO-ONLY TELEPHONE

(a) As used in this section:

(1) "Health care provider" means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual's medical care, treatment, or confinement.

(2) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402; Medicaid, to the extent permitted by the Centers for Medicare and Medicaid Services; and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The term does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(b)(1) A health insurance plan shall provide coverage for all medically necessary, clinically appropriate health care services delivered remotely by audio-only telephone to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this subdivision shall include services that are covered when provided in the home by home health agencies.

(2) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered by audio-only telephone provided that it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(3) A health insurance plan shall not require a health care provider to have an existing relationship with a patient in order to be reimbursed for health care services delivered by audio-only telephone.

Sec. 5. 18 V.S.A. chapter 219 is amended to read:

CHAPTER 219. HEALTH INFORMATION TECHNOLOGY AND ~~TELEMEDICINE~~ TELEHEALTH

* * *

Subchapter 2. ~~Telemedicine~~ Telehealth

* * *

§ 9362. HEALTH CARE PROVIDERS DELIVERING HEALTH CARE SERVICES BY AUDIO-ONLY TELEPHONE

(a) As used in this section, "health insurance plan" and "health care provider" have the same meaning as in 8 V.S.A. § 4100l and "telemedicine" has the same meaning as in 8 V.S.A. § 4100k.

(b)(1) Subject to the limitations of the license under which the individual is practicing and, for Medicaid patients, to the extent permitted by the Centers for Medicare and Medicaid Services, a health care provider may deliver health care services to a patient using audio-only telephone if the patient elects to receive the services in this manner and it is clinically appropriate to do so. A health care provider shall comply with any training requirements imposed by the provider's licensing board on the appropriate use of audio-only telephone in health care delivery.

(2) A health care provider delivering health care services using audio-only telephone shall include or document in the patient's medical record:

(A) the patient's informed consent for receiving services using audio-only telephone in accordance with subsection (c) of this section; and

(B) the reason or reasons that the provider determined that it was clinically appropriate to deliver health care services to the patient by audio-only telephone.

(3)(A) A health care provider shall not require a patient to receive health care services by audio-only telephone if the patient does not wish to receive services in this manner.

(B) A health care provider shall deliver care that is timely and complies with contractual requirements and shall not delay care unnecessarily if a patient elects to receive services through an in-person visit or telemedicine instead of by audio-only telephone.

(c) A health care provider delivering health care services by audio-only telephone shall obtain and document a patient's oral or written informed consent for the use of audio-only telephone prior to the appointment or at the start of the appointment but prior to delivering any billable service.

(1) The informed consent for audio-only telephone services shall be provided in accordance with Vermont and national policies and guidelines on the appropriate use of telephone services within the provider's profession and shall include, in language that patients can easily understand:

(A) that the patient is entitled to choose to receive services by audio-only telephone, in person, or through telemedicine, to the extent clinically appropriate;

(B) that receiving services by audio-only telephone does not preclude the patient from receiving services in person or through telemedicine at a later date;

(C) an explanation of the opportunities and limitations of delivering and receiving health care services using audio-only telephone;

(D) informing the patient of the presence of any other individual who will be participating in or listening to the patient's consultation with the provider and obtaining the patient's permission for the participation or observation;

(E) whether the services will be billed to the patient's health insurance plan if delivered by audio-only telephone and what this may mean for the patient's financial responsibility for co-payments, coinsurance, and deductibles; and

(F) informing the patient that not all audio-only health care services are covered by all health plans.

(2) For services delivered by audio-only telephone on an ongoing basis, the health care provider shall be required to obtain consent only at the first episode of care.

(3) If the patient provides oral informed consent, the provider shall offer to provide the patient with a written copy of the informed consent.

(4) Notwithstanding any provision of this subsection to the contrary, a health care provider shall not be required to obtain a patient's informed consent for the use of audio-only telephone services in the case of a medical emergency.

(5) A health care provider may use a single informed consent form to address all telehealth modalities, including telemedicine, store and forward, and audio-only telephone, as long as the form complies with the provisions of section 9361 of this chapter and this section.

(d) Neither a health care provider nor a patient shall create or cause to be created a recording of a provider's telephone consultation with a patient.

(e) Audio-only telephone services shall not be used in the following circumstances:

(1) for the second certification of an emergency examination determining whether an individual is a person in need of treatment pursuant to section 7508 of this title; or

(2) for a psychiatrist's examination to determine whether an individual is in need of inpatient hospitalization pursuant to 13 V.S.A. § 4815(g)(3).

Sec. 6. AUDIO-ONLY TELEPHONE; MEDICAL BILLING; DATA COLLECTION; REPORT

(a)(1) On or before July 1, 2021, the Department of Financial Regulation, in consultation with the Department of Vermont Health Access, the Green Mountain Care Board, representatives of health care providers, health insurers, and other interested stakeholders, shall determine the appropriate codes or modifiers, or both, to be used by providers and insurers, including Vermont Medicaid to the extent permitted by the Centers for Medicare and Medicaid Services, in the billing of and payment for health care services delivered using audio-only telephone in order to allow for consistent data collection, identify appropriate codes for services that do not have in-person equivalents, and minimize the administrative burden on providers. To the extent possible, the use of codes or modifiers, or both, shall be done in a manner that allows data on the use of audio-only telephone services to be identified using the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES).

(2) Not later than January 1, 2022, all Vermont-licensed health care providers and health insurers offering major medical health insurance plans in Vermont shall use the codes and modifiers determined by the Department of Financial Regulation pursuant to subdivision (1) of this subsection when delivering services by audio-only telephone. Vermont Medicaid shall participate to the extent permitted by the Centers for Medicare and Medicaid Services.

(b) On or before December 1, 2023, the Department of Financial Regulation, the Vermont Program for Quality in Health Care, and, to the extent VHCURES data are available, the Green Mountain Care Board shall present information to the House Committee on Health Care and the Senate Committee on Health and Welfare regarding the use of audio-only telephone services in Vermont during calendar year 2022. The Department shall consult with interested stakeholders in order to include in its presentation information on utilization of audio-only telephone services, quality of care, patient satisfaction with receiving health care services by audio-only telephone, the impacts of coverage of audio-only telephone services on health care costs and on access to health care services, and how best to incorporate audio-only telephone services into value-based payments.

Sec. 7. AUDIO-ONLY TELEPHONE REIMBURSEMENT AMOUNTS FOR PLAN YEARS 2022, 2023, AND 2024

The Department of Financial Regulation, in consultation with the Department of Vermont Health Access, the Green Mountain Care Board, representatives of health care providers, health insurers, and other interested stakeholders, shall determine the amounts that health insurance plans shall reimburse health care providers for delivering health care services by audio-only telephone during plan years 2022, 2023, and 2024. In determining the reimbursement amounts, the Department shall seek to find a reasonable balance between the costs to patients and the health care system and

reimbursement amounts that do not discourage health care providers from delivering medically necessary, clinically appropriate health care services by audio-only telephone. The Department may determine different reimbursement amounts for different types of services and may modify the rates that will apply in different plan years as appropriate but shall finalize its determinations not later than April 1 for plan years after 2022.

Sec. 8. TELEPHONE TRIAGE SERVICES; DEPARTMENT OF FINANCIAL REGULATION; EMERGENCY RULEMAKING

Notwithstanding any provision of 3 V.S.A. § 844 to the contrary, the Department of Financial Regulation shall consider adopting, and shall have the authority to adopt, emergency rules to address health insurance coverage of and reimbursement for telephone calls used to determine whether an office visit or other service is needed. Emergency rules adopted pursuant to this section shall remain in effect until not later than April 1, 2022.

Sec. 9. 8 V.S.A. § 4100k(a)(2) is amended to read:

(2)(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply:

(i) to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services; or

(ii) in the event that a health insurer and health care provider enter into a value-based contract for health care services that include care delivered through telemedicine or by store-and-forward means.

Sec. 10. 18 V.S.A. § 9721 is amended to read:

§ 9721. ADVANCE DIRECTIVES; COVID-19 STATE OF EMERGENCY; REMOTE WITNESSES AND EXPLAINERS

* * *

(c)(1) Notwithstanding any provision of subsection 9703(b) of this title to the contrary, an advance directive executed by a principal between June 15, 2020 and June 30, ~~2021~~ 2022 shall be deemed to be valid even if the principal signed the advance directive outside the physical presence of one or both of the required witnesses, provided all of the following conditions are met with respect to each remote witness:

* * *

(d)(1) Notwithstanding any provision of subsection 9703(d) or (e) of this title to the contrary, an advance directive executed by a principal between February 15, 2020 and June 30, ~~2021~~ 2022 while the principal was being admitted to or was a resident of a nursing home or residential care facility or was being admitted to or was a patient in a hospital shall be deemed to be valid

even if the individual who explained the nature and effect of the advance directive to the principal in accordance with subsection 9703(d) or (e) of this title, as applicable, was not physically present in the same location as the principal at the time of the explanation, provided the individual delivering the explanation was communicating with the principal by video or telephone.

* * *

Sec. 11. [Deleted.]

Sec. 12. EFFECTIVE DATE

This act shall take effect on passage.

Date Governor signed bill: March 29, 2021

VERMONT

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Deadline For Public Comment

Deadline: Unavailable.

The deadline for public comment is unavailable for this rule. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	21-E08
Title:	Access to Health Care Services Related to COVID-19.
Type:	Emergency
Status:	Adopted
Agency:	Department of Financial Regulation
Legal Authority:	Act No. 6 of 2021 § 3.
Summary:	The emergency rule requires health insurers to provide continuing coverage of COVID-19 diagnosis, testing, and treatment without member cost-sharing.

Persons Affected:	The emergency rule primarily affects health insurers, pharmacy benefit managers, and members of health insurance plans.
Economic Impact:	The Department anticipates that the emergency rule will provide substantial financial relief to Vermonters who still require access to COVID-19 testing and treatment. Vermont's regulated health insurers continue to be in a strong financial position going into plan year 2022, and the emergency rule is not expected to have a material effect on their solvency or ability to pay claims.
Posting date:	Jul 01,2021

Hearing Information

There are not Hearings scheduled for this Rule

Contact Information

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Keyword Information

Keywords:

Health Insurance
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