What Healthcare Providers Need to Know About the CARES Act

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On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), the third and by far the largest stimulus package passed by Congress to respond to the COVID-19 outbreak. As discussed in our main alert, the $2 trillion CARES Act amounts to what will be the biggest economic stimulus package in American history.

For healthcare providers struggling to cope with an unprecedented influx of critically ill patients and limited, scarce resources (ranging from limited hospital beds, medical equipment such as ventilators, and personal protective equipment in short supply), the stimulus comes at a time of great need.

The cornerstone of the Act for healthcare providers is a $100 billion appropriation in emergency funding broadly available to healthcare providers responding to COVID-19 with funds disbursed through an application process administered by the Department of Health and Human Services (HHS). Healthcare providers serving the Medicare population will also benefit from a temporary freeze on 2% mandatory cuts to Medicare under budget sequestration in place since March 1, 2013. Under the final legislation, hospitals, physicians, nursing homes, home health agencies, and other furnishing care to Medicare beneficiaries would see this increased payment boost from May 1, 2020 through December 31, 2020.

Other key provisions include a dramatic expansion in HHS's ability to **waive Medicare telehealth flexibilities**, opening up a pathway for Medicare beneficiaries to receive telehealth services from a broader range of providers and, potentially, through a broader range of technologies. The CARES Act also creates a new Medicare "add-on" for hospital inpatients diagnosed with COVID-19 during the public health emergency, increasing Medicare payment rates by 20% for this critical population. Finally, Part A providers and Part B suppliers will be able to apply for accelerated payments through an expanded program from the Centers for Medicare & Medicaid Services (CMS) for unbilled or unpaid claims (click HERE for CMS' Fact Sheet on the expanded Accelerated and Advance Payment Program).

Lastly, the Act also continues the so-called "**health extenders**", including a delay in the pending Medicaid Disproportionate Share Hospital Payment (DSH) cuts through November 30, 2020. Included in the health extenders are a number of critical provisions for safety net providers and programs, including an extension in funding for federally qualified community health centers (FQHCs), teaching health center graduate medical education (GME payments), and the Money Follows the Person demonstration

We discuss these and other key provisions for healthcare providers below.

Key Points

- **$100 Billion Appropriation for Healthcare Providers Responding to COVID-19.** Perhaps garnering more press attention than all of the other healthcare-related provisions in the latest stimulus bill put together, and for good reason, the Act appropriates **$100 billion** to broadly "prevent, prepare for, and respond to" COVID-19. Notably the language in the appropriation is left broad, granting the Secretary of HHS wide discretion to administer these funds, through grants or otherwise, to "eligible health care providers" for "health care related expenses or lost revenues" attributable to COVID-19. Congress also left immensely broad the definition of providers to whom payments can be made – they include Medicare or Medicaid enrolled suppliers and providers, public entities, and any entity in the United Sates that "provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." The level of discretion granted to HHS by Congress cannot be overstated. While Congress directs HHS to establish a process whereby providers must submit an application setting forth their need for funds in order to receive a grant, and to require grant recipients to submit relevant reports and documentation, there are very few strings for how these dollars must be

spent and how they are paid. So, for example, the appropriation will allow for funds to be expended on a variety of non-healthcare items and services, including: construction of temporary buildings, leasing of properties, purchase of medical supplies and PPE, workforce training, and more. Providers interested in grant funding should be on the watch for grant/funding opportunities in the near future from HHS. We expect HHS to develop an application process in the coming days and weeks, as well as to issue more detailed guidance on funding priorities, opportunities, and restrictions.

- **$1.32 Billion for FQHCs.** In addition to the $100 billion fund for health care providers generally, the CARES Act specifically authorizes $1.32 billion in supplemental funding for the detection, prevention diagnosis, and treatment of COVID-19 by FQHCs. We anticipate such funding will be administered similar to existing section 330 funding.

- **Relief From the 2% Medicare Sequester.** The Budget Control Act of 2011, and later the American Taxpayer Relief Act of 2012, put in place a mandatory budget sequestration, resulting in a 2% reduction in Medicare fee-for-service claims beginning March 1, 2013. For example, since 2013 a physician providing a service for which Medicare allows $100 has been paid a rate of $78.40 (($100 X 80%) – 2% = $78.40). Section 3709 of the CARES Act prevents this 2% reduction from applying from May 1, 2020 through December 31, 2020. Hospitals, physician, skilled nursing facilities, home health agencies, and other Medicare providers and suppliers will see a temporary increase in payments during this time period. Note that to account for this temporary freeze, the legislation also extends the effect of sequestration by a year (now through fiscal year 2030).

- **Hospital Add-on for COVID-19 Services.** Acute care hospitals are currently paid for inpatient hospital services furnished to Medicare beneficiaries based on a beneficiary's assignment to a particular diagnosis-related group, or MS-DRG. Depending upon a beneficiary's diagnosis and severity of illness, at discharge, a patient is assigned to a particular MS-DRG, which has a pre-assigned payment rate from the Medicare program. In most cases, the payment made to a hospital for a particular MS-DRG is agnostic to the types of services and procedures a Medicare inpatient receives, incentivizing hospitals to use resources wisely in managing any given patient. In recognition of the extraordinary efforts and unanticipated costs involved in managing patients with COVID-19 in the inpatient setting, section 3710 of the Act increases the weighting factors applied to the MS-DRG to which any given COVID-19 patient is assigned by 20%. CMS will identify eligible discharges through the use of diagnosis and/or condition codes and will implement the payment add-on through program instruction, meaning we expect the process to be in place in relatively short-order. Note that effective April 1, 2020, CMS has established a new diagnosis code, U07.1, to identify cases of COVID-19. Depending on the procedure codes and demographic information of the patient, one of several MS-DRGs will be assigned.

- **Broad New Telehealth Flexibilities in Medicare.**To address some inherent limits in the current Medicare telehealth benefit (for example, in most cases a Medicare provider is only paid for telehealth services provided to a beneficiary physically present in a healthcare facility in a rural area), on March 4, 2020 President Trump signed into law the *first* COVID-19 supplemental (the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020) extending flexibilities to HHS in administering the telehealth benefit. In particular, that legislation allows a Medicare beneficiary to receive telehealth services from any location, including their own home. Still, it left in place a number of restrictions, including the limitation on who can be a "qualified" telehealth provider and the types of equipment that must be used in a telehealth encounter.

The Act includes a number of provisions enhancing the flexibility and available of telehealth benefits. Section 3703 grants the Secretary of HHS broad authority to waive *any* of the existing Medicare telehealth requirements. Going forward, we expect HHS will use this authority to issue guidance further relaxing who can provide telehealth services, and in what settings. So, too, section 3704 gives FQHCs new flexibilities to furnish telehealth services to beneficiaries in their homes, paying providers at rates comparable to telehealth services under the Medicare Physician Fee Schedule. Section 3705 waives the face-to-face requirement for home dialysis patients, allowing increased use of telehealth for Medicare patients receiving home dialysis. Finally, section 3706 of the Act permits the physician recertification visit authorizing an extension of the hospice benefit to be conducted via telehealth during the emergency period.

- **New Flexibilities for IRFs and LTC Hospitals.** Recognizing the need for flexibility in managing patient populations between settings of care, section 3711 makes several technical changes designed to remove barriers to hospitals transferring patients out to their facilities and into either Inpatient Rehabilitation Facilities (IRFs) or Long Term Care Hospitals (LTCHs) to free up much-needed bed space. With respect to IRFs, the Act freezes the so-called 3-hour rule, which requires IRFs to provide 3 hours of therapy per day to patients, at least five days per week. With respect to LTCHs, the Act pauses the current site-neutral payment methodology applicable to LTHCs that has been in place since 2016 under the Pathway for SGR Reform Act of 2013, and similarly waives a requirement that a LTCH must have no more than 50% of its Medicare cases paid at the site-neutral rate to receive the otherwise fee-schedule payable rate.We understand that some state hospital associations have also asked CMS for additional flexibilities for IRFs, and CMS is considering those requests separately from implementation of the Act.

- **Expanding the Medicare Accelerated Payment Program**. While Medicare already has in place an "Accelerated and Advance Payment Program" to allow providers and suppliers of Medicare covered items and services in financial distress to receive an accelerated or advance payment, section 3719 of the Act expands this program by increasing the types of facilities eligible for the program, by expanding the amount of payment available, and lengthening the period for repayment/recoupment. On March 28. 2020 CMS issued a Fact Sheet on the expanded Accelerated and Advance Payment Program, including a step-by-step guidance for how to request such payments by submitted a request to the appropriate Medicare Administrative Contractor (MAC). Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals will be able to request up to 100% of the Medicare payment amount for a six-month period. Critical access hospitals (CAH) will be able request up to 125% of their payment amount for a six-month period. These hospital providers will have up to one year from the date the accelerated payment was made to repay the balance. All other Part A provider and Part B suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period, and have 210 days from the date the accelerated payment was made to repay the balance.

- **New Home Health Flexibilities**. Recognizing the need for many COVID-19 patients to receive certain services in their own home as well as the important role of direct support professionals in the acute care setting, the Act implements a number of new flexibilities in these areas. First, section 3707 directs HHS to issue guidance on ways to encourage the use of telehealth, including remote patient monitoring, when furnishing telehealth services to Medicare beneficiaries in their homes. Second, under current law only a physician can order home health services for a Medicare beneficiary. To address what could be a back-log of orders, section 3708 permanently expands the providers that can order home health to include physician assistants, nurse practitioners, and clinical nurse specialists. In addition to directing the Secretary of HHS to issue rulemaking on this new scope of practice expansion, it also extends this same authority to the Medicaid program.

Finally, section 3715 expands Medicaid's home and community-based services benefit (typically provided by states under waivers) to the acute hospital setting. In particular, the C Act authorizes payment by a State Medicaid program for home and community-based services (such as assistance with activities of daily living) furnished in the acute care hospital setting so long as: (1) the services are identified in an individual's person-centered service plan; (2) provided to meet the needs of the individual that are not met through the provision of hospital services; (3) not a substitute for hospital services; and (4) designed to ensure smooth transitions between the acute and community-based settings./p>

Looking Ahead

The breadth and scope of the CARES Act is unprecedented and it is unsurprising that may of its most critical provisions (and most significant dollar amounts) are focused on those at the frontline of the COVID-19 crisis: healthcare providers. In the coming days and weeks we expect additional information from the Federal agencies tasked with implementing these provisions, including applications for Federal grant funding specific to healthcare providers responding to the public health emergency.

Foley Hoag has formed a firm-wide, multi-disciplinary task force dedicated to client matters related to the novel coronavirus (COVID-19). For more guidance on your COVID-19 issues, visit our Resource Page or contact your Foley Hoag attorney. For guidance on CARES Act healthcare provider issues, please contact Tom Barker or Ross Margulies.

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