Key Health Care Provisions of the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”)

On Friday, March 27, the Coronavirus Aid, Relief, and Economic Security Act (the “CARES Act”) was enacted. Organized below are concise summaries of select CARES Act sections that will impact various sectors of the health care industry:

Appropriation of Funds

Among the many appropriations authorized by the CARES Act, Congress appropriated:

$100,000,000,000 to Medicare and Medicaid enrolled suppliers and providers, as well as other entities, that provide diagnosis, testing, or care for individuals with possible or actual cases of COVID-19, in order to prevent, prepare for, and respond to coronavirus, including for necessary health care related expenses or lost revenues attributed to coronavirus. Without limitation, these funds can be used for expenses such as building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment...
and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.

The funds will be contributed to and distributed by the Public Health and Social Services Emergency Fund, which is administered by HHS’ Assistant Secretary for Preparedness and Response (ASPR). ASPR will accept and review provider and supplier applications for funds, which must include a statement justifying the provider’s need for the funds. Applicants need only have a valid TIN. As of the date of this writing, ASPR had not announced plans for its application, review, and distribution processes.

$250,000,000 to grantees and sub-grantees of the Hospital Preparedness Program, also administered by ASPR.

$180,000,000 to HRSA, to carry out telehealth and rural health activities to prevent, prepare for, and respond to coronavirus, such funds to remain available until September 30, 2022.

3211 – Appropriates, for fiscal year 2020, $1,320,000 in funds for the detection, prevention, diagnosis and treatment of COVID-19 by health centers serving a medically underserved population.

3212 – Appropriates, for each of fiscal years 2021 through 2025, $29,000,000 for telehealth network and telehealth resource center grant programs. Unlike in previous telehealth grant programs, grants will be available to both for-profit and non-profit entities. Grants will also be available for up to five years, unlike previous similar grants that were limited to four year terms.

3213 – Appropriates for each of fiscal years 2021 through 2025, $79,500,000 for rural health care services outreach, rural health network development, and small health care quality improvement grant programs. Rural health care services outreach and rural health network development grants, unlike previous such grants, will be available to for-profit private entities with demonstrated experience serving or the capacity to serve rural underserved populations, although small health care quality improvement grants will still be limited to rural public and nonprofit private providers. Grants will also be available for up to five years, unlike previous similar grants that were limited to three year terms.

3831 – Increases and extends funding for Community Health Centers (by ~$2,000,000,000), the National Health Services Corps. (by $310,000,000), and Teaching Health Centers operating graduate medical education programs (by ~$21,000,000 for a two-month period).

**Federal Health Care Program Reimbursement, Rates of Payment, and Coverage**

*Accelerated Payments for All Eligible Medicare Enrolled Providers and Suppliers*

3719 – In order to increase immediate cash flow to acute care hospitals, children’s
hospitals, certain cancer hospitals, and critical access hospitals, Section 3719 expands Medicare’s accelerated payment program (APP) during the COVID-19 emergency. Specifically, hospitals can request and receive accelerated payments up to 100% of what they would otherwise receive (or 125% of what critical access hospitals would otherwise receive) for a period covering up to 6 months. These payments would effectively be ‘advances’, as HHS would have (i) no longer than 120 days to begin recouping the payments through offset of claims; and (ii) to recoup all payments within 12 months. Congress authorized these accelerated payments “subject to appropriate safeguards against fraud, waste, and abuse.”

On March 28, 2020, CMS published a fact sheet implementing the APP. CMS has extended the program not just to hospitals, but to all “providers of services and suppliers impacted” by COVID-19. A provider may request specific amounts of payments from its MAC and is eligible if it (1) has billed Medicare within the last 180 days, (2) is not in bankruptcy, (3) is not under active medical review or program integrity investigation, and (3) does not have any outstanding, delinquent Medicare overpayments. It is not clear the extent to which MACs will refuse to issue advances to providers who are under active medical review or program integrity investigations; many such investigations conclude without penalty or refund, and it is difficult to comprehend why the conclusion of a medical review should stand in the way of COVID-19 response efforts. CMS further indicated that:

- Request forms are available on MAC websites, and can be submitted via email;
- MACs will work to review and issue payments within 7 calendar days;
- Most providers will be able to request up to 100% of the Medicare payment amount for a 3-month period (although hospitals can request up to 6 months’ payment);
- Providers and suppliers must begin repaying the advances within 120 days (by way of claims offset), and repay the outstanding balance, if any, by way of direct payment on day 210 (hospitals will have one year to repay the balance in full).

CMS’ Fact Sheet is available [here](#).

**Hospitals, Including Increased Payments for Treating COVID-19 Patients**

**3710** – During the COVID-19 emergency, increases by 20% the weighting factor applied to DRGs for discharges of hospital inpatients diagnosed with COVID-19. Such discharges are identifiable by diagnosis codes, condition codes, and other means. On March 20, 2020, and effective April 1, 2020, the CDC established a new ICD-10-CM code, U07.1, COVID-19. For health care encounters and deaths related to COVID-19 but preceding April 1, 2020, the CDC has published [coding guidelines](#).

**3711** – During the COVID-19 emergency, provides acute care hospitals the flexibility to transfer patients out of their facilities and into alternative care settings for resources needed to treat COVID-19 patients. Specifically:

- Waives the Inpatient Rehabilitation Facility (IRF) 3-hour rule, which requires
that a beneficiary be required to participate in at least 3 hours of intensive rehabilitation therapy at least 5 days per week;

- Allows a Long Term Care Hospital (LTCH) to maintain its designation even if more than 50% of its cases are less intensive than typically required for an LTCH; and

- Pauses the current site-neutral payment methodology.

3813 – Delays reductions in disproportionate share hospital (DSH) payments by one year.

3715 – Extends the pre-existing clarification (that Medicaid payments to hospitals serving a disproportionate number of low-income patients for home and community care should not be limited) to apply to Medicaid payments for certain community-based services, self-directed personal assistance services, and community-based attendant services and supports, including when such services are provided in an acute care hospital if designed to transition the patient back to functioning within the patient’s home or community.

**Expansion of Coverage of Services Provided Through Telehealth**

3703 – Revises the previous legislative authorization for HHS to waive originating site requirements and restrictions on the use of telephones during an emergency by removing the limitation of the waiver to patients seen by a provider in the last three years. This expansion may be more ministerial than practically relevant, as CMS had already declined to adopt this limitation and waived requirements and restrictions for all qualifying telehealth services, regardless of the provider’s previous relationship with the patient (if any).

3704 – Allows for payment, during an emergency, to federally qualified health centers (FQHCs) and rural health clinics (RHCs) that provide telehealth services that correspond to telehealth services that can be billed under the physician fee schedule. HHS will develop and implement payment methods for such services “based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule”, and is allowed to do so “through program instruction or otherwise”, presumably to speed to develop and publish rates. Also provides that telehealth service costs will be excluded from determination of FQHC payment under the FQHC prospective payment system, and of RHC payment under the methodology for all-inclusive rates. This provision helps to clarify Congress’ intent that FQHCs and RHCs receive payment for telehealth services furnished during the COVID-19 emergency, but its efficacy will depend heavily on CMS’ rapid publication and implementation of billing and payment instructions.

3705 – During the COVID-19 emergency, eliminates the requirement that, in order for home dialysis patients to receive monthly renal disease-related clinical assessments via telehealth, they must first have had prior face-to-face clinical assessments on a defined periodic basis.

3706 – During the COVID-19 emergency, allows physicians and nurse practitioners
to conduct via telehealth the face-to-face encounters required prior to the 180-day recertification for ongoing hospice care.

3707 – HHS must consider ways to encourage the use of telecommunications systems for the provision of home health services during the COVID-19 emergency, including for remote patient monitoring, in a manner consistent with the beneficiary’s individual plan of care. Recommends that HHS issue clarifying guidance.

**Coverage of COVID-19 Testing and Vaccination**

3201 – Expands coverage for all tests for COVID-19 that are approved, cleared, or authorized by the FDA (whether under emergency use authorization or otherwise), tests authorized by a state, and any other tests the Secretary determines appropriate in guidance.

3203 – A “qualifying coronavirus preventive service” is (1) an evidence-based item or service that has an “A” or “B” recommendation from the United States Preventive Services Task Force, or (2) an immunization recommended by the Advisory Committee on Immunization Practices of the CDC for the individual involved.

3713 – A COVID-19 vaccine, when available and licensed, will be covered under Medicare Part B and Medicare Advantage without cost-sharing.

**Home Health**

3708 – Expands the types of health care professionals authorized to certify the need for home health services to include not only physicians, but nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives as well. This will reduce delays and increase Medicare beneficiary access to care in the home.

**DME Suppliers**

3712 – During the COVID-19 emergency, prevents scheduled payment adjustments (reductions) in Medicare payments for durable medical equipment (DME) in rural and non-contiguous areas (Alaska, Hawaii, and U.S. Territories), for DME provided through December 31, 2020.

**Clinical Laboratories**

3718 – Delays by one year the upcoming reporting period for clinical laboratories (which are required to report their private payer rates on an annual basis, causing annual adjustments to government fee schedule amounts for diagnostic tests). Prevents anticipated payment reductions for one year.

**Generally**

3709 – Exempts the Medicare program, until December 31, 2020, from any
reductions due to a sequestration order.

**Privacy and Confidentiality**

**3221** – Modifies the confidentiality requirements regarding substance abuse (now substance use disorder) records to be more aligned with HIPAA. Once prior written consent is obtained, records may be used by covered entities, business associates and covered programs for payment, treatment and health care operations (PTO) consistent with HIPAA. Information disclosed for such purposes may be redisclosed in accordance with HIPAA. Patient consent is only required once for PTO purposes, and shall be effective until the consent is revoked. Records that are de-identified in accordance with HIPAA may be disclosed to public health authorities. HHS is required to issue guidance within 180 days of enactment of the CARES Act on the sharing of protected health information (PHI) during the COVID-10 emergency. Includes a broad prohibition on discrimination against an individual on the basis of information received pursuant to an inadvertent or unintentional disclosure of records. Makes the breach notification requirements of the HITECH Act applicable to the breach of substance use disorder records.

**3224** – Requires HHS to issue guidance within 180 days after enactment of the CARES Act on the sharing of PHI regarding COVID-19 during the current emergency.

**Drugs, Devices, and Manufacturers**

**3103** – Adds National Institute for Occupational Safety & Health-approved respirators that the Secretary deems to be a priority as a “covered countermeasure” for purposes of liability protections for use during a pandemic.

**3112** – Adds drugs, including active pharmaceutical ingredients, that are critical in a public health emergency, to the list of drugs requiring reports to FDA of potential drug shortage. Also adds a requirement that manufacturers of any drug subject to shortage report to FDA to develop redundancy risk management plans to address risks to the supply of the drug.

**3121** – Requires manufacturers of medical devices that are critical in a public health emergency to notify FDA of a potential shortage of the device. Adds provisions for the prioritized and expedited review of device applications and inspection of facilities that could help mitigate or prevent a shortage. Under this new provision, FDA will maintain an up-to-date list of medical devices subject to shortage.

**Medicare Advantage, Part D, and Commercial Health Plan Coverage**

**3202** – Group health plans or health insurance issuers that cover COVID-19 testing must reimburse providers of COVID-19 testing at (1) pre-emergency negotiated rates, or (2) if there’s no pre-emergency negotiated rate, an amount equal to the cash price of the testing as listed by the provider on a public website, or a newly negotiated rate less than the cash price. Providers are required to post the cash price for COVID-19 tests on the provider’s public website; noncompliant providers may be subject to civil monetary penalties of up to $300 per day.
Health insurers offering group or individual health insurance must cover any qualifying coronavirus preventive service, without cost-sharing, within 15 days of being recommended by the CDC.

During the COVID-19 emergency requires Medicare prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) to permit enrollees to obtain a single fill or refill, at the enrollee's option, of a covered Part D drug for up to a 90 day supply without regard to any cost and utilization management, medication therapy management or other program. PDP and MA-PD safety edits are unaffected by the change.

Extends the Families First Coronavirus Response Act of 2020 requirement that insurers and health plans provide coverage of COVID-19 testing with no cost-sharing to all available COVID-19 tests, not just those that are “approved, cleared, or authorized” by the FDA.

Health Savings Accounts

Amends definitions within the Internal Revenue Code to allow individuals covered by high deductible plans that do not apply a deductible to telehealth or other remote services to be treated as eligible individuals covered by high deductible plans, and therefore to deduct the amounts they contribute to health savings accounts.

Expands the definition of qualified medical expenses for purposes of health savings accounts, health flexible spending arrangements and health reimbursement arrangements to include a “menstrual care product”, which is defined to mean a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation and other genital-tract secretions. The amendment applies to expenses incurred after December 31, 2019.

Given the speed with which COVID-19 has prompted a wide-range of legal action at the federal, state and local governmental levels, this blog article is not exhaustive. Things are changing quickly and there is no clear-cut authority or bright line rules. This is not an unequivocal statement of the law, but instead represents our best interpretation of where things currently stand. This post does not address the potential impacts of the numerous other local, state and federal orders that have been issued in response to the COVID-19 pandemic.

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