Health Law Alert: CARES Act Includes Funding Opportunities and Additional Flexibilities for Providers; CMS Makes Accelerated Payment Program Available to All Providers

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The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), was signed into law on March 27, 2020. The primary goal of the new law is to stabilize the U.S. economy and create the tools necessary to stem the rising tide of the COVID-19 public health emergency. However, the CARES Act contains a number of provisions of direct interest to health care providers. These provisions include significant increases in funding intended to directly assist providers in offsetting some of the costs they are incurring in tackling the COVID-19 outbreak, to targeted payment changes that only affect very specific categories of providers, to infusions of funds intended to improve the overall operation of the U.S. public health system. Just days after passage of the CARES Act, CMS expanded eligibility to participate in the Accelerated Payment Program to all provider and supplier categories and directed Medicare contractors to process requests for funds within seven days of receiving a provider or supplier's application. A summary of some of the key provisions for providers is outlined below.

Key Provisions of CARES Act for Health Care Providers

1. *$100 Billion in Revenue Pool to Aid Providers*. Health care providers are facing unprecedented challenges in tackling the patient care demands associated with treating COVID-19. The Public Health and Social Services Emergency Fund, which was created by Congress in 2005 in the aftermath of Hurricane Katrina, received an infusion of $100 billion to aid hospitals, physicians and other providers and suppliers (and such other organizations as HHS designates) in responding to the outbreak. The money can be used to reimburse qualifying entities for lost revenues attributable to COVID-19. The U.S. Department of Health and Human Services (HHS) will process applications for these funds on a rolling basis. The funding method that will be used to distribute the payments is not clear, with the law explaining it will occur through "the most efficient payment systems practicable." Recipients will be required to submit reports to HHS so that the agency can monitor compliance with the requirements of the program.
2. *Increased Reimbursement for Hospitals & Availability of Accelerated Payments.* Hospitals will receive an increase in inpatient reimbursement (through a positive adjustment in relevant diagnosis related group weighting factor) for patients who are treated for COVID-19. HHS also expanded the existing opportunity under Medicare Part A for hospitals to obtain accelerated payments during the ongoing public health

emergency. The list of hospitals eligible to receive these payments was expanded to include critical access hospitals, cancer hospitals and children's hospitals (in addition to hospitals paid under Medicare's inpatient prospective payment system). The program will permit eligible hospitals to obtain access to advance payments (for up to six months) for services provided during the public health emergency. In addition, the period of time for HHS to recoup the accelerated payments has been extended to give recipients more time to pay the money back.

3. *Opportunity for Non-Hospital Providers and Suppliers to Obtain Accelerated Payments.* While the CARES Act limited the expanded availability for accelerated payments to hospitals, CMS acted quickly in the past week to extend the opportunity to participate to other categories of Part A providers and Part B suppliers. Under the new guidance, all categories of providers and suppliers appear eligible to participate and receive advance payments. This is done by filing an application with the Medicare Administrative Contractor (MAC) in the provider's/supplier's jurisdiction. Applicants are directed to request a specific dollar amount from the MAC. There are certain eligibility requirements that applicants must meet, but they are fairly straightforward. MACs are supposed to process applications and issue payments within seven days of the request.
4. *Variety of Medicare and Medicaid Reimbursement Cuts Put on Hold*. HHS will delay a variety of payment cuts scheduled to come into effect in 2020. For example:
    - Cuts in Medicare payments based on 2015's sequestration program (that were scheduled to come into place on May 1, 2020) are eliminated.
    - Cuts for clinical lab reimbursement paid under the Medicare Clinical Laboratory Fee Schedule (set to become effective in 2021) are delayed until 2022. Clinical labs also get a one year respite on reporting their commercial payor reimbursement rates to CMS, which is required under the Protecting Access to Medicare Act of 2014.
    - Hospitals get a reprieve in the form of a delay in scheduled disproportionate share payment cuts. The scheduled $4 billion in cuts is pushed from May 23, 2020 to December 1, 2020.
    - Qualifying long term care hospitals will receive a delay of reimbursement cuts (imposed as a result of HHS' site neutrality policy) while treating patients during the COVID-19 emergency.
    - Payment cuts slated to become effective for DMEPOS suppliers under the Competitive Bidding Program established in 2003 are put on hold until the end of the COVID-19 emergency.
5. *Additional Funding for Community Health Centers*. An additional $1.32 billion is made available in supplemental awards for community health centers and rural health clinics for prevention, diagnosis and treatment of COVID-19. The process for obtaining this funding will be administered by the Health Resources and Services Administration.
6. *Expanded Opportunity for Telehealth Services*. The CARES Act made a variety of modifications to existing regulatory guidelines governing how health care services can be provided via telehealth. All of these changes are intended to expand access to services through this technology. Modifications include expanding the list of telehealth services Medicare will reimburse, expanding federally qualified health centers' and rural health clinics' ability to provide services via telehealth (and paying them at a rate that is consistent with Part B reimbursement for these services); permitting face-to-face encounters to be performed via telehealth for purposes of recertifying patient eligibility for hospice services; and granting HHS the authority to let providers use telehealth for purposes of remote patient monitoring for home

health services. In addition, the law deleted a requirement added earlier in the month (in a related piece of legislation) that the patient needed to have been treated within the past three years by a provider within the provider's practice for telehealth reimbursement to be available during the COVID-19 emergency.

7. *Expanded Coverage of COVID-19 Related Services*. Under the law, Medicare Part B will fully cover COVID-19 vaccines without any beneficiary cost-sharing. Parts C and D of Medicare are required to cover a 90-day supply of prescribed drugs without restrictions. Group health plans are required to reimburse providers at the parties' fully negotiated rate for diagnostic tests (if such a rate was in place in the provider's contract with the payor prior to the public health emergency) or the provider's publicly available cash price for the service. Providers, meanwhile, are required to publicly disclose their pricing for COVID-19 diagnostic tests. HHS is granted the authority to impose civil monetary penalties against a provider that fails to comply with this reporting requirement. Group health plans are also required to cover (without cost-sharing) preventive services and immunizations for COVID-19.
8. *Certain Rules Relaxed for Post-Acute Providers*. Changes include waiving the requirement that patients of inpatient rehabilitation facilities receive at least 15 hours of therapy per week; permitting Medicaid coverage of home and community based services provided in acute care hospitals; and expanding the list of practitioners who can order home health services to include nurse practitioners, clinical nurse specialists and physician assistants.
9. *HIPAA and Substance Use Disorder Records*. The CARES Act amends the statutory provisions governing substance use disorder records (commonly referred to as "Part 2") to create more conformity with HIPAA. In the past, many providers have struggled to reconcile the privacy rules that apply to substance use disorder treatment records with the more generally applicable rules that apply to health information under HIPAA. Under the changes enacted in the CARES Act, records can be used and disclosed by health care providers, business associates and substance use disorder programs for treatment, payment and healthcare operations purposes after the patient consents. Re-disclosures of this information are governed by HIPAA.
10. *Public Health Preparedness.* Numerous changes intended to address the problems in supply chain functioning and public health preparedness are also included in the CARES Act. For example, the law requires the Strategic National Stockpile to acquire and store personal protective equipment and other supplies required to administer drugs, vaccines and biologics and allocates $16 billion for this purpose. Manufacturers of devices and drugs that are critical to the public health emergency are required to notify the FDA of "potential meaningful supply disruptions". Likewise, these manufactures are required to implement risk management plans for purposes of monitoring risks to the supply chain.
11. *Temporary or Permanent Changes?* Many of the reimbursement and programmatic changes outlined in the CARES Act are set to last only through the duration of the COVID-19 public health emergency. Given the evolving nature of the crisis and the crushing patient care and financial demands facing the health care industry, it is not clear whether Congress may take further action to make some of the policy changes outlined in the CARES Act permanent. Likewise, significant discretion is granted to HHS and other agencies to administer many of these modifications. Given the importance to the provider community around implementation of these changes and access to new funding streams, these agencies will be under significant pressure to act very quickly.

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If you have questions on the application of the CARES Act to health care providers or suppliers, please contact Jesse Berg, Tony Fricano or any member of Lathrop GPM's Health Law Team.