CARES Act Offers Assistance and Funding for Health Care Providers During the COVID-19 Pandemic

By Jennifer Bolton, Laurie Cohen, and Sarah Swank

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act, (the CARE Act or Act) was passed to provide emergency assistance and a health care response for individuals, families, and business affected by the 2020 novel coronavirus (COVID-19) pandemic.

This alert primarily focuses on the key health care provisions of the Act related to the delivery and financing of health care, which are generally located in Title III (Supporting America’s Health Care System in the Fight Against Coronavirus).

Enhanced provider reimbursement/Medicare advances/grant opportunities

Funding to providers of services and suppliers impacted by the Covid-19 pandemic

— Expands, during the emergency period, an existing Medicare accelerated payment program, which affords qualified Medicare providers and suppliers the opportunity to request an accelerated or advance payment. The advancement would be based on net reimbursement represented by unbilled discharges or unpaid bills. To learn more about the program and how to submit requests, refer to the Expansion of Accelerated and Advance Payments program for Providers and Suppliers During COVID-19 Emergency.

— Provides economic assistance for small businesses in the form of loans, grants, and debt relief as well as more narrowly tailored programs to incentivize employers to continue to employ its workers and to pay employee benefits. To learn more about the programs and initiatives to assist small business owners, please refer to the US Senate Committee on Small Business & Entrepreneurship.

To read Nixon Peabody’s recent alert on the employee benefits-related provisions of the CARES ACT, please click here. To read Nixon Peabody’s recent alert on how small businesses can access funding under the Small Business Administration’s Disaster Loans Program, please click here.

— Temporarily lifts the Medicare sequester, which reduces payments to providers by 2% from May
1 through December 31, 2020.

— During the emergency period, provides a 20% add-on to the diagnosis-related group (DRG) rate for patients with COVID-19 treated at rural and urban inpatient prospective payment system (IPPS) hospitals as well as children’s hospitals, cancer hospitals, and critical access hospitals.

— Prevents scheduled reductions in Medicare payments for durable medical equipment (DME) during the COVID-19 emergency period.

— Eliminates the $4 billion in Medicaid disproportionate share hospital (DSH) cuts in FY 2020 and reduces the cut for FY 2021 to $4 billion from $8 billion. Implementation of the FY 2021 cuts are delayed until Dec. 1, 2020. The Act does not add any additional cuts after the current end-date of FY 2025.

**Funding for the public health and social services emergency funds**

— $100 billion for a new program to provide grants to eligible health care providers (e.g., hospitals, public entities, nonprofit entities, and Medicare and Medicaid enrolled suppliers and institutional providers) to cover unreimbursed health care-related expenses or lost revenues attributable to the COVID-19 public health emergency. Funding will be on a rolling basis through “the most efficient payment systems practicable to provide emergency payment.”

— Approximately $27 billion, to remain available through 2024 to support research and development of vaccines, therapeutics, and diagnostics to prevent or treat the effects of coronavirus, including $16 billion for the strategic national stockpile for critical medical supplies, personal protective equipment, and life-saving medicine; at least $250 million for grants to or cooperative agreements with entities that are either grantees or sub-grantees of the Hospital Preparedness Program or meet other criteria; $3.5 billion for the Biomedical Advanced Research and Development Authority for necessary expenses of manufacturing, producing, and purchasing vaccines, therapeutics, diagnostics, and pharmaceutical ingredients; and $275 million for the Health Resources and Services Administration (HRSA), including $90 million for Ryan White HIV/AIDS programs and $195 million to support rural critical access hospitals, rural tribal health, and telehealth programs.

— Funding to be provided for the Department of Health and Human Services (HHS) to carry out duties related to quality measurement and performance improvement through November 30, 2020.

— Expands rural health care services grant programs to strengthen rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services. Included in the bill is an authorization of $79.5 million for each of fiscal years 2021 through 2025. The bill also will require a report on the activities and outcomes of these grant programs, including the impact of funded projects on the health status of rural residents with chronic conditions.

— Providing $1.32 billion in supplemental funding to community health centers on the front lines of testing and treating patients for COVID-19.

**Funding and policy changes regarding the provision of telehealth services**

— Reauthorizing HRSA grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services.
— Allowing a high deductible health plan with a health savings account to cover telehealth services prior to a patient reaching that deductible, thereby increasing access for patients who may have the COVID-19 virus and protecting other patients from potential exposure.

— Eliminating the requirement in the Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074) that limits the Medicare telehealth expansion authority during the COVID-19 emergency period to situations where the physician or other professional has treated the patient in the past three years. This will allow beneficiaries to access telehealth from a broader range of providers, reducing COVID-19 exposure.

— Allowing federally qualified health centers (FQHCs) and rural health clinics (RHCs), during the COVID-19 emergency period, to serve as a distant site for telehealth services to patients in their homes and other eligible locations. Medicare shall reimburse for these services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. Further, it excludes the costs associated with these services from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.

— Expanding telehealth for home dialysis patients, hospice care recertification, and home health services.

To read Nixon Peabody’s recent alert on how federal government and state leaders are enacting historic expansions of telehealth, please click here.

Funding to other agencies

— **Food and Drug Administration (FDA).** The Act provides $80 million to the FDA for work related to shortages of critical medicines, emergency use authorizations, and pre- and post-market work on medical countermeasures, therapies, vaccines, and research.

— **Defense Production.** The Act provides $1 billion to the Defense Department to invest in manufacturing capabilities in order to increase the production of personal protective equipment and medical equipment to meet the demand of health care workers nationwide.

— **Centers for Disease Control and Prevention (CDC).** The Act provides $4.3 billion to the CDC for coronavirus response, which includes the following:
  - $1.5 billion to support states, local governments, territories, and tribes to carry out conduct surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities with respect to coronavirus
  - $500 million for public health data surveillance and analytics infrastructure modernization
  - $500 million for global disease detection and emergency response
  - $300 million for the Infectious Diseases Rapid Response Reserve Fund, which supports immediate response activities during outbreaks

— **National Institutes of Health.** The Act provides $945 million to support research—including developing an improved understanding of the prevalence of COVID-19, its transmission and the natural history of infection, and approaches to diagnosing the disease and past infection—and develop countermeasures for the prevention and treatment of its various stages.

— **Centers for Medicare & Medicaid Services (CMS).** The Act provides $200 million for CMS to
prevent, prepare for, and respond to coronavirus, and, of that amount, $100 million shall be available for expenses of its survey and certification, prioritizing nursing home facilities in places with community transmission of coronavirus.

— Veterans Affairs (VA). The Act provides approximately $16 billion to support an increase in demand for VA services specific to coronavirus. This covers the treatment of veterans nationwide for coronavirus within VA hospitals, community urgent care clinics, and emergency rooms. These funds allow the VA to cover overtime for their clinical staff, the purchase of personal protective equipment, test kits, and other necessary equipment to manage the impacts of this pandemic among the veteran population.

— Community health centers, the National Health Services Corps, and teaching health centers that operate graduate medical education programs. The Act extends mandatory funding for these programs at current levels through November 30, 2020.

Public health responses to pandemic

Addressing supply shortages

The Act includes a number of steps to address access to health care supplies, including medications. These include:

— Requiring certain medical supplies (e.g., personal protective equipment, ancillary medical supplies, supplies necessary for the administration of drugs, diagnostic tests, vaccines, and other biologic products and medical devices) to be included in the strategic national stockpile.

— Requiring the FDA to prioritize and expedite the review of drug applications and inspections to prevent or mitigate a drug shortage.

— Requiring manufacturer notification and reporting requirements in response to drug shortages, device shortages, or device component shortages.

— Covering National Institute of Occupational Safety and Health approved respirators under the Public Readiness and Emergency Preparedness Act, thereby allowing the use of those approved respirators as medical countermeasures during a public health emergency.

Access to health care for Covid-19 patients

The Act expands the types of diagnostic tests that must be covered by certain payers and clarifies several aspects of coverage reimbursement. These include:

— Requiring private insurance plans to cover all testing for COVID-19 without cost-sharing.

— For Covid-19 testing covered with no cost to patients, requiring an insurer to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider.

— Providing free coverage without cost-sharing of a vaccine within 15 days for COVID-19.

— Expanding the types of diagnostic tests that will be covered by commercial payers and public programs to include laboratory tests that have not been approved by the FDA, but meet certain conditions.

— Requiring health plans to cover, without cost-sharing, qualifying COVID-19 preventive services, such as an item, service, or immunization recommended by the U.S. Preventive Services Task Force or CDC’s Advisory Committee on Immunization Practices.
— Providing flexibility for post-acute care providers during the emergency period to transfer patients out of their facilities and into alternative care settings in order to prioritize resources needed to treat COVID-19 cases. Specifically, this includes waiving the inpatient rehabilitation facility (IRF) three-hour rule, which requires that IRF patients generally receive at least fifteen hours of therapy per week; temporarily pauses the current long-term acute care hospital (LTCH) site-neutral payment policy, which uses an IPPS-level payment rate for lower-acuity patients; and allows an LTCH to maintain its designation even if more than 50% of its cases are less intensive.

— Enabling beneficiaries to receive the COVID-19 vaccine with no cost-sharing.

— Requiring Medicare Part D plans to provide up to a 90-day supply of prescription medication if requested by a beneficiary during the COVID-19 emergency period.

— Ensuring that uninsured individuals can receive a COVID-19 test and related service with no cost-sharing in any state Medicaid program that elects to offer such enrollment option.

**Other key provisions**

The Act includes several other provisions relevant for providers, including:

— **Limitation on liability for volunteer health care professionals during COVID-19 emergency response.** Makes clear that licensed providers who provide volunteer medical services within their scope of license during the public health emergency related to COVID-19 have liability protections.

— **Importance of the blood supply.** The Act directs the HHS secretary to carry out a national campaign to improve awareness of, and support outreach to, the public and health care providers about the importance and safety of blood donation and the need for donations to the blood supply during the COVID-19 public health emergency.

— Updates on grant programs described above as well as more specific topics of interest to non-hospital providers (e.g., medical and dental practices, physical therapy providers, ambulatory surgery centers, clinics, urgent care centers) are expected to be addressed in future Nixon Peabody alerts.

Get the latest updates on the evolving COVID-19 pandemic. [New info posted regularly on nixonpeabody.com](http://nixonpeabody.com).

For more information on the content of this alert, please contact our [Coronavirus Response Team](mailto:CoronavirusResponseTeam@nixonpeabody.com), your Nixon Peabody attorney, or:

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