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ALERTS

# CARES Act Delivers Much-Needed COVID-19 Relief, Assistance To Healthcare Industry

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In the wake of the COVID-19 pandemic, the CARES Act provides, among other things, economic assistance to healthcare providers and entities providing coronavirus relief and services, including increasing Medicare program reimbursement, expanding telehealth services, offering regulatory flexibility for state Medicaid programs and healthcare providers, and ensuring small businesses have access to emergency funds and loan assistance.

This alert offers a summary of available CARES Act relief tailored explicitly to healthcare providers and suppliers. It does not address all of the new healthcare provisions in the CARES Act, but focuses on those provisions that are likely to deliver the most support to the healthcare industry.

## Emergency Funds and Loan Assistance

$100 Billion for COVID-19 Expenses

The CARES Act allocates $100 billion to the Public Health and Social Services Emergency Fund to assist eligible healthcare providers “to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for healthcare-related expenses or lost revenues that are attributable to coronavirus.” The act defines “eligible health care providers” as public entities, Medicare or Medicaid enrolled suppliers and providers, and other entities as determined by the US Secretary of Health and Human Services (HHS) that “provide diagnoses, testing, or care for individuals with possible or

### RELATED PRACTICE AREAS

COVID-19 Resources

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Healthcare

actual cases of COVID–19."

This allocation may not be used for any expenses or losses that are reimbursed from another source. To be eligible, the healthcare provider must submit to the HHS Secretary an application that includes a statement justifying the provider's need for payment, and maintain documentation and submit reports demonstrating eligible losses in a format yet to be established by the secretary. The funds available under this provision must be used for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment (PPE) and testing supplies, increased workforce and training, emergency operation centers, retrofitting facilities, and patient surge capacity.

The act requires HHS' Office of Inspector General (OIG) to perform audits and ensure compliance with this funding provision. It also requires the OIG to provide a final report on audit findings to the House and Senate Appropriations Committees, which indicates that there will be vigorous enforcement to prevent wasteful or fraudulent spending of federal funds.

Although the act establishes a new Special Inspector General for Pandemic Recovery, the signing statement by the president made clear that the Trump administration would not permit the special inspector general to issue reports to Congress without presidential approval. It is unclear whether President Trump's signing statement is an indication of the administration's desire to monitor enforcement or assert presidential powers; pundits believe if President Trump serves a second term, it is highly likely that prosecutorial decision-making regarding COVID-19 fraud, waste, and abuse will receive substantial oversight from the administration.

Accelerated and Advanced Medicare Payments Program for Providers

The CARES Act extends Medicare advanced payment protections usually reserved for natural disasters to healthcare providers or suppliers that have: billed a claim 180 days before the request is not in bankruptcy, not under investigation, and does not have any outstanding Medicare overpayments. Most providers and suppliers are eligible for up to 100 percent of their Medicare payment amounts for a three-month period. Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are eligible for 100 percent of their Medicare payment amounts for a six-month period. Critical access hospitals may avail themselves of up to 125 percent of their Medicare payment amounts for a six-month period.

Providers and suppliers are immediately eligible to apply for accelerated or advanced Medicare payments, and successfully processed requests will be funded within seven days of receipt. Providers and suppliers must use the Accelerated/Advanced Payment Request form distributed by their Medicare Administrative Contractor (MAC) to submit a request for advanced payment. An authorized representative to the provider or supplier must sign the request form. The Centers for Medicare & Medicaid Services (CMS) recommends that the provider or supplier submit the form electronically to reduce processing time.

Paycheck Protection Program Loans

The Keeping American Workers Paid and Employed Act, part of the CARES Act, provides $349 billion in guaranteed loans to small

businesses and other entities that have 500 employees or fewer, subject to increases depending on the industry. Eligible borrowers can obtain up to a $10 million loan based on 2.5 times of its average monthly payroll over a 12-month or annualized basis, depending on the nature of the business, before the COVID-19 outbreak in the United States. Such covered loans, to the extent not forgiven, would have up to a 10-year term with an interest rate not to exceed 4 percent. Loan proceeds can be used for payroll costs and other employee compensation (subject to certain limitations for employees who make more than $100,000 annually), group healthcare premiums and certain other related costs, mortgage interest payments, rent, utilities, and interest on any other debt obligations that were incurred prior to Feb. 15, 2020; and to refinance any loan that the borrower received under the Small Business Administration (SBA)'s disaster assistance loan program for small businesses impacted by COVID-19.

The loan program will be administered by the SBA through its existing Section 7(a) business loan program, which requires applying through an approved SBA lender, though certain requirements associated with typical SBA loans, such as guarantees, collateral, and a "credit available elsewhere" underwriting, have been relaxed or eliminated.

One of the most anticipated provisions of the loan program was the "forgivable" nature of the loan, where a borrower under a covered loan can have a portion of the principal forgiven in an amount equal to payroll costs, mortgage interest, rent, or utility costs during the eight weeks following the origination of the loan.

The CARES Act requires that any amount forgiven be reduced proportionally by any reduction in employees retained, compared to the prior year, and reduced by the decrease in the pay of any employee beyond 25 percent of their previous year compensation. The federal government will not penalize borrowers that rehire workers previously laid off for having a reduced payroll at the beginning of the period.

Hospital Preparedness Grants

The act allocates $250 million for grants and cooperative agreements with grantees or sub-grantees of the Hospital Preparedness Program under the Public Health Service Act. These funds are not short-term solutions, and are much more likely to be distributed to assist with long-term preparedness.

The Hospital Preparedness Program was created under the Consolidated Appropriations Act in 2008 and designates the majority of federal funds (ideally 75 percent or more) toward healthcare facilities – outpatient facilities and centers, inpatient facilities and centers, and other entities (e.g., poison control, emergency medical services, nursing) – to increase preparedness for pandemics. The program provides grant awards for enhanced preparedness activities that make the healthcare system more efficient, resilient, and coordinated during epidemics.

## Increased Reimbursement for Services

The CARES Act modifies the Medicare Hospital Inpatient Prospective Payment System and provides a 20 percent add-on to the diagnostic related group (DRG) rate for COVID-19 patients. The DRG rate traditionally provides hospitals reimbursement for an inpatient stay from

the time of admission to discharge based on weighing factors and provides payment based on an estimated relative cost of hospital resources expended for a particular injury, illness, or procedure. The act increases the reimbursement for DRG weighing factors by 20 percent for patients diagnosed with COVID-19 to ensure that hospitals are not financially responsible for COVID-19 expenses, which requires resource-intensive treatment. It is anticipated that CMS will identify and verify COVID-19 claims eligible for the increased DRG reimbursement through the use of diagnosis codes.

Another result of the CARES Act is temporary suspending Medicare sequestration required by The Budget Control Act of 2011 from May 1, 2020, through Dec. 31, 2020, which subjected the Medicare Program's budget to an annual reduction of up to 2 percent from 2013 to 2029. Although sequestration is put on hold through the end of 2020, Congress extended the sequestration program an additional year to ensure The Budget Control Act of 2011 meets its intended budget savings.

The CARES Act also suspends the long-term care hospital (LTCH) site-neutral policy, which reduced reimbursement for the "standard rate" if the patient was not directly admitted from a hospital after a three-day or longer stay or a four-day or longer stay with a procedure code for a ventilator. The suspension of this payment will temporarily restore the LTCH Prospective Payment System rates, which will provide increased reimbursement for roughly 30 percent of all LTCH stays and will provide LTCHs more flexibility in providing COVID-19 care. The act also suspended the 50 percent Rule for LTCHs, which required LTCHs to ensure 50 percent or more of its patients be admitted under the standard rate.

In addition, the  CARES Act suspends the Affordable Care Act's requirement to reduce the Medicaid Program's disproportionate share hospital (DSH) payments by $4 billion in 2020. Instead, the act delayed the $4 billion reduction in DSH payments until 2021, and it shifted the intended $8 billion reductions in DSH payments for years 2021 through 2024 back one year.

## Reimbursement Coverage and Financial Assistance for COVID-19 Testing

The CARES Act requires the Medicare program and state Medicaid programs to cover all COVID-19 diagnostic testing and vaccines without any patient cost-share. It also requires commercial insurance payers to provide cost-share-free COVID-19 diagnostic testing, vaccines, and preventive measures.

For COVID-19 testing, providers must be reimbursed by a commercial payer under a negotiated rate established between the provider and payer before the public health emergency declaration or at the cash price rate made public on the test manufacturer's website. The  act imposes a penalty on test manufacturers that fail to post a cash price on their website.

Congress also delayed laboratory reporting requirements for reporting market data to CMS under the Protecting Access to Medicare Act of 2014 (PAMA), which is used to establish payment rates under the Medicare Clinical Laboratory Fee Schedule. As a result, the PAMA reporting

requirements were moved from 2021 to 2022. Additionally, PAMA permitted the government to reduce laboratory reimbursement by up to 15 percent. Because of COVID-19, Congress capped the 2020 and 2021 reduction at 0 percent, and delayed the potential reduction of up to 15 percent to the years 2022 through 2025.

The CARES Act also allocated an additional $27 billion to the Public Health and Social Services Emergency Fund for the development of necessary countermeasures and vaccines. The vaccine fund prioritizes U.S.-based manufacturers and provides for the purchase of, among other things, vaccines, therapies, tests, supplies, telehealth services, and medical surge capacity.

## Assistance for Employers

Family First Coronavirus Response Act

On March 18, the Family and Medical Leave Act was expanded to guarantee paid sick leave for individual employees. Under this legislation, employers with fewer than 500 employees are required to provide up to two weeks of paid leave and 10 weeks at two-thirds pay of workers until the end of the year. Employees subject to local quarantine or an isolation order related to COVID-19, caring for a stricken family member, or with children whose schools or child care programs have closed are eligible for the initial two weeks of paid leave.

Paid leave is capped at $511 daily and up to $5,110 for leave related to quarantine/isolation or COVID-19 healthcare symptoms or concerns confirmed by a healthcare provider. Paid leave is capped at $200 daily and $2,000 total for individuals caring for an individual subject to a self-quarantine or isolation order.

Businesses that fall under the mandate would also have to provide an additional 10 weeks off at partial pay for people who have lost their child care because of school and day care closures. Paid leave due to child care-related COVID-19 school closures is capped at two-thirds of the employee's base salary up to $200 daily and $12,000 total.

To compensate employers for the paid leave, the law provides a credit against the employer portion of the social security tax component of its payroll taxes. To avoid a fine, employers must provide the following notice of the "employee rights" described above either in a conspicuous place in the business or provide each employee with a copy electronically.

Employers of healthcare providers may elect to exclude their employees from paid sick leave and expanded family and medical leave benefits under FFCRA. The Department of Labor's (DOL) definition of healthcare provider is broad and includes traditional healthcare workers, medical schools, third-party contractors of healthcare providers and entities, anyone deemed a healthcare provider by their highest state official, and manufacturers of PPE, tests, and others supplies. The DOL encouraged employers to be judicious when exempting health care providers from FFCRA.

CARES Act: Small Business Loan Forgiveness for Short-Team Payroll

While the CARES Act provides loan and loan forgiveness programs for eligible small businesses, sole proprietors, independent contractors, and

self-employed persons for payroll and other operating expenses, an employer considering short-term employee layoffs or furloughs may want to consider how such decisions could affect their borrowing ability and the extent to which the government may underwrite certain payroll and operating expenses for a period of short duration under the loan forgiveness program.

CARES Act: Work Share Programs

In states that have or will adopt a “short-time” compensation program, such programs will allow an employer to reduce hours for its workforce, and the state’s unemployment compensation programs will cover a portion of the reduced hours. For example, an employee whose hours have been reduced by 25 percent will be entitled to an unemployment compensation claim equal to 25 percent of the employee’s weekly unemployment benefit.

It is also important to note that the COVID-19 employment-related laws may intersect with the Family and Medical Leave Act and Americans with Disabilities Act, especially in the areas of employee requests for extended unpaid leave accommodations or an employer’s inquiry about an employee’s medical condition or request for medical examination or testing. Additionally, large-scale reductions in your company’s workforce could trigger WARN-Act obligations or other considerations for covered employers.

## Telehealth

Regulatory Flexibility

The Medicare program is notorious for its substantial limitations on telehealth services. The CARES Act addresses telehealth regulatory burdens and eases restrictions on Medicare and on healthcare providers. The CARES Act removes Medicare’s requirements that the patient must have been seen by the provider within the last three years and allows qualified providers to fulfill hospice face-to-face recertification requirements during the COVID-19 emergency period. The CARES Act also requires HHS to encourage the use of remote patient monitoring to secure home health services, and it permits a high-deductible health plan to provide coverage for telehealth services before a patient reaches their high deductible.

Additional Telehealth Financial Assistance

The CARES Act provides several different buckets of financial assistance to promote telehealth services, including:

- $14.4 billion for the Veterans Administration (VA) to address increased service demands through telehealth, which includes funds for the purchase of medical equipment, supplies, tests, and PPE
- $2.15 billion for the Department of Veterans Affairs’ Department of Information Technology to provide temporary, complimentary or subsidized, fixed and mobile broadband services to provide expanded mental health services to isolated veterans through telehealth or VA Video Connect during a public health emergency

- $180 million to Health Resources and Services Administration to promote and assist in the development and use of telehealth in rural areas

Drugs and Supplies

The CARES Act addresses the U.S.'s undersupply of devices, drugs and PPE for COVID-19 and future pandemics by building on the U.S. Food and Drug Administration's (FDA) manufacturer reporting requirements under the Federal Food, Drug, and Cosmetic Act requiring a manufacturer to notify the FDA of a permanent discontinuance or temporary interruption in the drug supply chain. The new FDA requirements demand that manufacturers provide additional information about present or anticipated drug shortages (such as disclosing an interruption caused by a missing ingredient and naming the missing ingredient) and provide contingency plans to ensure there is an adequate supply of life-saving and life-preserving products.

The CARES Act allocates $1 billion to the Department of Defense (DOD) to increase the rate of production for PPE and medical equipment. Using the Defense Production Act (DPA) and CARES Act funding, the DOD can conscript domestic manufacturers to make additional medical supplies required for the nation during times of crisis. The DPA also allows the DOD to assert "allocation authority," – informing manufacturers that the government has a right to purchase their products before any other party.

## Mental Health Assistance

Through the Substance Abuse and Mental Health Services Administration (SAMHSA), the CARES Act provides $425 million in funding for mental health services, that includes $250 million for Certified Community Behavioral Health Clinics, $50 million for suicide prevention programs, $100 million for emergency-response spending, and $15 million for tribal communities. The act also provided $4 billion in Homeless Assistance Grants through the Department of Housing and Urban Development to address COVID-19 homelessness issues.

## HIPAA and Mental Health Records

Unexpected to many, the act created changes to 42 USC. § 290dd-2 (colloquially known as 42 CFR Part 2 or Part 2) of the Health Insurance Portability and Accountability Act (HIPAA). Most notably, this law is not dependent upon the COVID-19 emergency declaration and will continue to govern the disclosure of substance use disorder records after the COVID-19 emergency response ends.

The most substantial change occurred to the effect of patient consent. Under the CARES act, once a patient provides prior written consent under Part 2, the contents of that patient's medical record "may be used or disclosed by a covered entity, business associate, or a [Part 2 program] for purposes of treatment, payment, and health care operations as permitted by the HIPAA regulations." This permission mirrors Part 1. The act also aligned Part 2 more closely with HIPAA Part 1 by subjecting Part 2 breaches of protected health information to the HIPAA Breach Notification Rule, applies the civil and criminal penalties for Part 1 violations to Part 2, and requires providers provide an accounting to

patients for all HIPAA disclosures for treatment, payment, and healthcare operations.

## Federal Flexibility for State Medicaid Programs

The act modifies federal Medicaid program mandates for states to provide extra flexibility to states to address and respond to the COVID-19 pandemic. To free up additional hospital beds and reduce the length of stay, it also allows states to provide reimbursement for direct support professionals providing assistance to disabled individuals in hospital settings. Additionally, the CARES Act requires states to eliminate patient cost-sharing obligations under the Families First Coronavirus Response Act –which allows states to expand their Medicaid Program to provide COVID-19 tests and related services to uninsured individuals. Finally, the CARES Act provides states a 30-day grace period to determine whether it will reduce its Medicaid premiums to 2019 levels to be eligible for the 6.2 percent increase in the Federal Medical Assistance Percentage under the Families First Coronavirus Response Act.

## Liability Protection

The CARES Act provides liability protection for volunteer healthcare professionals and respiratory protective devices (e.g., ventilators), that are designed to increase the number of healthcare personnel and respiratory protective devices available for the COVID-19 pandemic. The act exempts a healthcare professional that provides healthcare services during a public health emergency from liability, as long as the provider is volunteering, the services provided are within the scope of their license, and the services are provided under a good faith belief that the individual treated requires healthcare services. The CARES Act also provides permanent liability protection for manufacturers of respiratory protective devices during a public health crisis.

To obtain more information regarding this alert, contact the Barnes & Thornburg attorney with whom you work or Robert M. Castle at 214-258-4149 or robert.castle@btlaw.com, Douglas D. Haloftis at 214-258-4137 or doug.haloftis@btlaw.com, or Jason Myers at 214-258-4157 or jason.myers@btlaw.com, or Matthew Agnew at 214-258-4153 or matthew.agnew@btlaw.com.