

March 27, 2020

House Passes the Coronavirus Aid, Relief, and Economic Security (CARES) Act

Legislation includes provisions important to hospitals and health systems

The House today by voice vote passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act ([H.R. 748](#)). The legislation is the third large-scale congressional effort in response to the novel coronavirus (COVID-19) outbreak. The Senate passed the bill 96-0. President Trump is expected to sign it.

The legislation provides financial relief and resources to individuals, families and businesses particularly hard hit by the COVID-19 public health emergency. It also includes a number of important health care provisions. An emergency fund for hospitals and health systems, a Medicaid Disproportionate Share Hospital (DSH) cut delay, temporary elimination of the Medicare sequester, and a Medicare diagnosis-related group (DRG) add-on payment together are estimated to make available \$117 billion in new funding for urban and rural hospitals and health systems. We continue to evaluate the potential financial impact of new loan opportunities.

AHA Take: In a [statement](#) after the Senate passed the legislation, AHA said the legislation will help those hospitals from rural and urban communities that are in dire financial need due to this devastating pandemic.

While this legislation is an important first step forward, more will need to be done to deal with the unprecedented challenge of this virus. We will continue to work with Congress to make sure providers on the front lines — hospitals, physicians and nurses — remain prioritized for future federal assistance as the COVID-19 pandemic spreads.

Key Takeaways

Among other health care-related provisions, the package:

- Increases funding to the Public Health and Social Services Emergency Fund by almost \$127 billion to, among other things, reimburse hospitals for COVID-19 expenses;
- Creates a Medicare add-on payment of 20% for both rural and urban inpatient hospital COVID-19 patients;
- Removes the Medicare sequester from May through December 2020;
- Expands the existing option for hospitals to receive “accelerated” Medicare payments, including by ensuring critical access hospitals can access this option;
- Eliminates \$8 billion in total Medicaid DSH cuts over FY 2020 (eliminates \$4 billion cut) and FY 2021 (reduces cut to \$4 billion from \$8 billion);
- Provides flexibility to post-acute care providers, including waiving long-term care hospital (LTCH) site-neutral policy;
- Takes steps to improve the supply chain, including access to masks and drugs, among other items;
- Takes steps to expand coverage for COVID-19 testing and testing-related services; and
- Provides new telehealth flexibilities, including expanding access in rural areas.

The following Special Bulletin provides information on the key provisions related to the delivery and financing of health care, but does not address all of the elements that may affect hospitals and health systems as employers and incorporated entities, such as a number of loan and payroll tax provisions. Watch for more information on those components of the legislation.

HIGHLIGHTS OF PROVISIONS RELEVANT TO HOSPITALS & HEALTH SYSTEMS

Public Health and Social Services Emergency Fund. The bill increases funding for the Public Health and Social Services Emergency Fund, including by:

- \$100 billion to reimburse eligible health care providers for health care-related expenses or lost revenues not otherwise reimbursed that are directly attributable to COVID-19. Eligible providers are defined as public entities, Medicare- or Medicaid-enrolled suppliers and providers, and other for-profit and non-profit entities as specified by the Health and Human Services (HHS) Secretary. Funding will be on a rolling basis through “the most efficient payment systems practicable to provide emergency payment;”
- \$27 billion, to remain available through fiscal year (FY) 2024, to fund activities such as developing vaccines, and purchasing vaccines, diagnostics and medical surge capacity. It funds workforce modernization, telehealth access and other preparedness and response activities. At least \$250 million of these funds must be made available to entities that are part of the Hospital Preparedness Program. In addition, at least \$16 billion of these funds must be used to purchase products for the Strategic National Stockpile; and
- \$275 million to remain available until Sept. 30, 2022, for the services administered under the Health Resources and Services Administration (HRSA), of which \$180 million will need to be used to carry out telehealth and rural health activities. Included within this amount is \$15 million that is allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

Medicare Payment Improvements and Flexibilities. The bill provides additional funds to providers caring for Medicare beneficiaries.

Sequester. It eliminates the Medicare sequester from May 1 through Dec. 31, 2020.

DRG Add-on. During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. This add-on will apply to patients treated at rural and urban inpatient prospective payment system (IPPS) hospitals.

Expanded Option for Accelerated Payments. It also expands the Medicare hospital accelerated payment program during an emergency. Specifically, in addition to IPPS hospitals, the bill expands the program to children’s hospitals, cancer hospitals and critical access hospitals (CAHs). All eligible providers are able to request accelerated payments for inpatient services that cover a time period of up to six months. The amount of payment is up to 100% (or up to 125% for CAHs) of what the hospital would have

otherwise received, up from 70% in the current program, and payment could be made periodically or as a lump sum. The bill also extends the timeframe for recoupment of the accelerated payment: hospitals will have up to 120 days until their claims are offset to recoup the funds, and at least 12 months before being required to pay any outstanding balance in full. Currently, the program requires full recoupment within 90 days of the accelerated payment being issued.

Additional Post-acute Care Flexibilities. The legislation provides flexibility for post-acute care (PAC) providers so they are able to increase the capacity of the health care system, without penalty, during the emergency period. This includes waiving:

- the inpatient rehabilitation facility (IRF) 3-hour rule, which requires that IRF patients generally receive at least three hours of therapy a day;
- LTCH site-neutral payment policy, which uses an IPPS-level payment rate for lower-acuity patients; and
- the LTCH “50% Rule,” which requires that greater than 50% of patients be paid a standard LTCH PPS rate for the hospital to maintain an LTCH designation.

Medicaid Financing. Several of the provisions will increase Medicaid financing for states.

Medicaid DSH. The legislation eliminates the \$4 billion in Medicaid 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 legislation does not add any additional cuts after the current end-date of FY 2025.

Delay Premium MOE Requirement for Temporary Increase in Federal Medicaid Matching Funds. The legislation delays the application of the maintenance of effort (MOE) requirement that restricted states from increasing premiums as a condition of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase, as authorized by Families First Coronavirus Response Act. The MOE would not take effect for 30 days from date of enactment if a state had in effect a premium increase as of the date of enactment. The previous provision restricted state premium increases as of Jan. 1, 2020. States will have 30 days to come into compliance with this MOE requirement. In addition, the legislation ensures that COVID-19 related unemployment benefits would not count as income for an individual applying for Medicaid or the Children’s Health Insurance Program (CHIP).

Clarification of State Medicaid Option to Cover the Uninsured. The legislation clarifies that non-expansion states can use the Medicaid program to cover COVID-19-related services for uninsured adults who would have qualified for Medicaid if the state had chosen to expand. It also clarifies that other populations with limited Medicaid coverage, such as impoverished pregnant women and individuals who are eligible because they have certain health conditions, also are eligible for coverage under this state option.

Medicare and Medicaid Extenders. The legislation will extend a number of Medicare and Medicaid programs and policies, including the Work Geographic Practice Cost Index (GPCI), the Money Follows the Person demonstration program, spousal impoverishment

protections under Medicaid, and the Certified Community Behavioral Health Clinics demonstration program (with two additional states participating), among others.

Home-based Services. The bill makes a number of policy changes regarding the provision of home-based health care services, which seek to increase access and decrease patient risk during the emergency period.

Face-to-Face Visits between Home Dialysis Patients and Physicians. This provision will reduce requirements during the COVID-19 emergency that pertain to face-to-face evaluations for home dialysis patients.

Enabling Additional Health Professionals to Order Home Health Services. This provision will expand the ability of physician assistants, nurse practitioners and certified nurse specialists with regard to the certification of home health services and document-related requirements.

Facilitating Home and Community-based Support Services during Hospital Stays. This provision will expand certain state and community-based services guidelines to include self-directed personal assistance services and attendant services and supports. Many of these policy changes also will apply to Medicaid home health services.

Telehealth. The legislation will make a number of policy changes regarding the provision of telehealth services, which may increase access during the emergency period. These include:

Medicare Telehealth Flexibilities. This section will eliminate the requirement included in the Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074) that providers or others in their group must have treated the patient in the past three years to provide them with a telehealth service during the ongoing public health emergency. The net result of this section and Section 102 of the Telehealth Services During Certain Emergency Periods Act of 2020 – a subpart of H.R. 6074 – will be to give the HHS Secretary authority to waive, among other policies, the geographic and originating site requirements of Section 1834(m) of the Social Security Act (the Act) as he sees fit, without restrictions on the definition of “qualified provider.”

Enhancing Medicare Telehealth Services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) during Emergency Period. Subject to a section 1135 emergency declaration, this legislation will waive the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as distant sites. Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule.

Using Telehealth for Hospice Recertification. This section allows hospice recertifications to be completed via telehealth, rather than a face-to-face visit, during the emergency period.

Access to Health Care Supplies. The legislation will take a number of steps to address access to health care supplies, including medications. These include:

Supplies to be Included in the Strategic National Stockpile (SNS). The legislation will amend the Public Health Service Act to require that certain medical supplies and drugs be included in the strategic national stockpile. Specifically, it will require the inclusion of personal protective equipment, ancillary medical supplies, supplies necessary for the administration of drugs, diagnostic tests, vaccines and other biologic products and medical devices.

Actions Aimed at Evaluating the Medical Product Supply Chain. The legislation will require HHS to enter into an agreement with the National Academies to produce a report assessing and evaluating the medical device and pharmaceutical supply chain. The report would emphasize critical drugs and devices and provide recommendations on redundancy, domestic manufacturing and improved information sharing in an effort to mitigate disruptions in the future. In addition, this bill will require certain types of medical supplies to be included in the SNS and will cover National Institute of Occupational Safety and Health-approved respirators under the Public Readiness and Emergency Preparedness (PREP) Act, allowing the use of those approved respirators as medical countermeasures during a public health emergency.

Mitigating Emergency Drug Shortages (MEDS Act). The legislation includes a version of the MEDS Act, which will require additional manufacturer notification and reporting requirements in response to drug shortages; a Government Accountability Office report on intra-agency coordination focused on drug manufacturing and application prioritization; and a report within two years of passage on encouraging the manufacturing of drugs in shortage or at risk of being in shortage.

Preventing Essential Medical Device Shortages. The bill will place new requirements on device manufacturers to notify the HHS Secretary of potential or likely shortages due to discontinuance or interruption during or in advance of a public health emergency. It also allows for expedited inspection and review to curb any potential shortages. Specific devices that will be covered are those that are life-supporting, life-sustaining, used in emergency medical care or during surgery. The list will be made publicly available unless otherwise determined by the HHS Secretary and will include relevant information about the device and the reason for the shortage.

Coverage of COVID-19 Testing and Other Services. The legislation will expand the types of diagnostic tests that must be covered by certain payers and clarifies several aspects of coverage reimbursement. These include:

Coverage of Diagnostic Tests and Preventive Services. The legislation includes several provisions related to coverage and reimbursement for COVID-19 testing and testing-related services. The legislation will expand the types of diagnostic tests that will be covered to include laboratory tests that have not been approved by the Food and Drug Administration (FDA) but meet certain conditions, including that the applicable state or territory has assumed responsibility for the validity of the tests. The legislation then

directs certain commercial payers and public programs to cover this broader range of tests.

Health plans are directed to pay providers of laboratory services the full negotiated rate or, if the provider and plan do not have a contract in place, they must reimburse the provider the cash price for the service. Each provider of such laboratory services will be required to post a cash price for COVID-19 testing on a public website and failure to comply could result in civil monetary penalties. In addition, health plans are required to cover qualifying COVID-19 preventive services such as an item, service or immunization recommended by the US Preventive Services Task Force or CDC's Advisory Committee on Immunization Practices.

High Deductible Health Plan (HDHP) Exemption for Telehealth Services. This section allows HDHPs with HSAs to cover telehealth services before a patient reaches his or her deductible amount.

Other Provisions. The legislation includes several other provisions relevant for hospitals and health systems, including:

Small Business Loans via the "Paycheck Protection Program." The legislation will make available loan opportunities for organizations with less than 500 total employees (i.e., both full time and part time employees). These loans may be up to \$10 million and may be forgivable. They could be used to pay salaries, leave and health benefits, rent, and/or retirement obligations, among other uses. Both for-profit and non-profit hospitals will be eligible for these loans; however, affiliation rules will apply. The affiliation rules are intended to determine whether the organization, taking into account the "totality of circumstances," is operating as part of a larger organization and therefore not considered a small business, which will be evaluated on a case-by-case basis.

Payroll Tax Delay. The legislation will delay payment of payroll taxes for many employers within some criteria. Employers may be either for-profit or nonprofit and may be eligible as long as they have not taken a Small Business Administration loan that has been forgiven. The employer can defer paying the tax they would have owed as the 6.2% employer portion of FICA between date of enactment and Dec. 31, 2020. Instead, the employer can pay 50% by Dec. 31, 2021 and the other 50% by December 31, 2022.

Other Business Loans through the Federal Reserve. The legislation authorizes business loans using the Federal Reserve's emergency lending authority. While these loans may be available to a wide range of businesses, the legislation directs the Treasury to endeavor to implement loan programs specifically targeted for nonprofit organizations and businesses between 500 and 10,000 employees, subject to additional loan criteria and obligations on the recipient. These include that the funds received be used to retain at least 90% of the recipient's workforce, with full compensation and benefits, through September 30, 2020; that the recipient will not outsource or offshore jobs for the term of the loan plus an additional two years; that the recipient will not abrogate existing collective bargaining agreements for the term of the loan plus an additional two years; and that the recipient must remain neutral in any union organizing effort for the term of the loan.

Blood Supply Awareness Campaign. The legislation will direct 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 for the blood supply during the public health emergency.

Family and Medical Leave and Sick Leave Policies. The legislation will amend the changes to the family and medical leave and sick leave policies established by the Families First Coronavirus Response Act to limit the total amount employers may have to pay under each benefit, among other changes.

Sharing of Substance Use Disorder Records with Patient Consent. This section will allow records pertaining to substance use disorder (SUD) treatment or other activities to be used or disclosed to covered entities for the purposes of treatment, payment or health care operations as permitted by HIPAA once a patient's written consent has been obtained. It also will allow disclosures of de-identified health information from these records to public health authorities as defined by HIPAA. The section will prohibit the use of this information for use in any civil, criminal, administrative or legislative proceedings (except as otherwise authorized), and contains an antidiscrimination clause ensuring that the information may not be used in decisions around treatment, employment, housing, access to courts or social services. Patients still will have the right to request restrictions on the use or disclosure of their SUD treatment records. Finally, this section will require an update to the regulations in no less than one year so that covered entities will be required to provide notice in plain language on their privacy practices to patients.

Expand Certain HRSA Grants for Rural Entities. The bill will expand rural health care services outreach grants, rural health network development grants, and small health care provider quality improvement grants. Specifically, the bill will increase the time period of grants from three to five years and focus the grants on assistance to rural underserved populations. In addition, for rural health care services outreach and rural health network development grants, the bill will remove the eligibility criterion of public or non-profit status; instead, eligible entities must "be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations." For the quality improvement grants, the bill will include as quality improvement activities related to increasing care coordination, enhancing chronic disease management, and improving patient health outcomes. 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.

Other Health Care Appropriations. The legislation will provide funding for a number of other health care agencies and programs, including:

Food and Drug Administration. The bill will provide \$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 Act. The bill will provide \$1 billion to the Defense Department to invest in manufacturing capabilities in order to increase production of personal protective equipment and medical equipment to meet the demand of healthcare workers nationwide.

Expansion of Military Hospitals. The legislation will provide \$1.5 billion to nearly triple the 4,300 beds available in military treatment facilities today.

Indian Health Service (IHS). The bill will provide \$1.032 billion to support the tribal health system during the pandemic, including support for medical services, equipment, and supplies, new investments for telehealth services, and expanded disease surveillance.

Centers for Disease Control and Prevention. The bill will provide \$4.3 billion to the CDC for coronavirus response, including \$1.5 billion to support states, local governments, territories, and tribes; \$500 million for public health data surveillance and analytics infrastructure modernization; and \$1.5 billion for efforts to contain and combat the virus, among other uses.

National Institutes of Health. The bill will provide \$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 developing countermeasures for the prevention and treatment of its various stages.

Centers for Medicare & Medicaid Services. The bill will provide \$200 million for CMS to assist nursing homes with infection control and support states' efforts to prevent the spread of coronavirus in nursing homes.

Child Care Development Block Grant. The bill will support child care by appropriating \$3.5 billion for the Child Care Development Block Grant, allowing child care programs to maintain critical operations, including meeting emergency staffing needs and ensuring first responders and health care workers can access child care.

Veterans Affairs. The bill will provide nearly \$16 billion in order to support an increase in demand for VA services specific to coronavirus. This covers treatment of veterans nationwide for coronavirus within VA hospitals and community urgent care clinics and emergency rooms. These funds allow 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.

FURTHER QUESTIONS

If you have questions, please contact AHA at 800-424-4301.