CORNERSTONE

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MEMORANDUM

TO: Interested Clients
FROM: Cornerstone Government Affairs
SUBJECT: The CARES Act: Resources for Hospitals
DATE: March 26, 2020

This memo focuses on the health appropriations and health policy provisions of the third COVID-19 supplemental bill, known as the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The Senate passed the legislation last night, and the House of Representatives is expected to pass the legislation tomorrow.

This comprehensive package contains significant appropriations, as well as additional policy provisions, that impact our nation's hospitals and health providers. A top-line breakdown of the appropriations portion is as follows:

- $100 billion for hospitals through a new program within the Assistant Secretary for Preparedness and Resources (ASPR) to help hospitals and health care providers with COVID-related expenses and lost revenue;
- $27 billion for the Biomedical Advanced Research and Development Authority (BARDA), including
  - $16 billion for the Strategic National Stockpile to buy personal protective equipment, ventilators and other needed medical supplies;
  - $3.5 billion for vaccine creation, manufacturing, and distribution; and
  - $250 million for the Hospital Preparedness Program, including the National Ebola and Special Pathogens Training and Education Center (NETEC) to improve hospital capacity
- $275 million for the Health Resources and Services Administration (HRSA), including
  - $185 million to support rural critical access hospitals, rural tribal health and telehealth programs, and poison control centers
- $200 million for the Centers for Medicare & Medicaid Services (CMS) for infection control in skilled nursing facilities
- $4.3 billion for the Centers for Disease Control (CDC), including
  - $1.5 billion in additional resources for state and local health offices;
  - $500 million for enhanced national surveillance, diagnostics and lab supports; and
  - $500 million for global health efforts
- $945 million for the National Institutes of Health (NIH) for vaccine, therapeutic and diagnostic research
- $425 million for Substance Abuse and Mental Health Services Administration (SAMHSA) to address mental health and substance use disorders, including
  - $250 million for Certified Community Behavioral Health Clinics;
  - $50 million for suicide prevention; and

    - $100 million in flexible funding to address mental health, substance use disorders, and provide resources and support to youth and the homeless during the pandemic
- $80 million for Food and Drug Administration (FDA)
- $1.032 billion for Indian Health Services

Relevant Health Policy Changes

The package includes significant additional health policy changes, which we have outlined below for your review.

Section 3101. Requires the National Academies report to study the manufacturing supply chain of drugs and medical devices and provide Congress with recommendations to strengthen the U.S. manufacturing supply chain.

Section 3102. Requires the strategic national stockpile to include certain types of medical supplies, such as the swabs necessary for diagnostic testing for COVID-19.

Section 3103. Provides permanent liability protection for manufacturers of personal respiratory protective equipment, such as masks and respirators, in the event of a public health emergency, to incentivize production and distribution.

Section 3111. Requires the Food and Drug Administration (FDA) to prioritize and expedite the review of drug applications and inspections to prevent or mitigate a drug shortage.

Section 3112. Requires drug manufacturers to submit more information when there is an interruption in supply, including information about active pharmaceutical ingredients, when active pharmaceutical ingredients are the cause of the interruption. Requires manufacturers to maintain contingency plans to ensure back up supply of products. Requires manufacturers to provide information about drug volume.

Sec. 3121. Clarifies that during a public health emergency, a medical device manufacturer is required to submit information about a device shortage or device component shortage upon request of the FDA.

Section 3201. Clarifies that all testing for COVID-19 is to be covered by private insurance plans without cost sharing.

Section 3202. For COVID-19 testing, requires 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.

Section 3203. Provides free coverage without cost-sharing of a vaccine within 15 days for COVID-19 that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) or a recommendation from the Advisory Committee on Immunization Practices (ACIP).

Section 3211. Provides $1.32 billion in supplemental funding to community health centers for testing and treating patients for COVID-19.

Section 3212. Reauthorizes HRSA grant programs for the development of telehealth technologies for health care delivery, education, and health information services.

Section 3213. Reauthorizes HRSA grant programs to strengthen rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services.

Section 3214. Establishes a Ready Reserve Corps to ensure we have enough trained doctors and nurses to respond to COVID-19 and other public health emergencies.

Section 3215. Clarifies that doctors who provide volunteer medical services during the public health emergency related to COVID-19 have liability protections.

Section 3216. Allows the Secretary of Health and Human Services (HHS) to reassign members of the National Health Service Corps to sites close to the one to which they were originally assigned, with the member's agreement, in order to respond to the COVID-19 public health emergency.

Section 3221. Allows for additional care coordination by aligning the 42 CFR Part 2 regulations with Health Insurance Portability and Accountability Act (HIPAA), with initial patient consent.

Section 3224. Requires HHS to issue guidance on what is allowed to be shared of patient records during the public health emergency related to COVID-19.

Section 3225. Reauthorizes Healthy Start, which is a program that provides grants to improve access to services for women and their families, who may need additional support during the COVID-19 public health emergency.

Section 3226. Directs the Secretary of HHS to carry out an initiative to improve awareness of the importance and safety of blood donation and the continued need for blood donations during the COVID-19 public health emergency.

Section 3301. Allows BARDA to more easily partner with the private sector on research and development by removing the cap on other transaction authority (OTA) during a public health emergency.

Section 3302. Provides Breakthrough Therapy designations for animal drugs that can prevent human diseases – i.e. speed up the development of drugs to treat animals to help prevent animal-to-human transmission, which is suspected to have occurred with outbreak of novel coronavirus, leading to the SARS-CoV-2 pandemic.

Section 3401. Reauthorizes health professions workforce programs.

Section 3402. Health workforce coordination.

Section 3403. Reauthorizes and updates Title VII of the Public Health Service Act (PHSA), which pertains to programs to support training in family medicine, general internal medicine, geriatrics, pediatrics, and other medical specialties.

Section 3404. Reauthorizes and updates Title VIII of the PHSA, which pertains to nurse workforce training programs. Permits Nurse Corps loan repayment beneficiaries to serve at private institutions under certain circumstances.

Sec. 3701. Allows a high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible, increasing access for patients who may have the COVID-19 virus and protecting other patients from potential exposure.

Sec. 3702. Allows patients to use funds in HSAs and Flexible Spending Accounts for the purchase of over-the-counter medical products, including those needed in quarantine and social distancing, without a prescription from a physician.

Sec. 3703. Eliminates the requirement in Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (Public Law 116-123) 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 would enable beneficiaries to access telehealth, including in their home, from a broader range of providers, reducing COVID-19 exposure.

Sec. 3704. Allows Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to serve as a distant site for telehealth consultations. A distant site is where the practitioner is located during the time of the telehealth service. This section would allow FQHCs and RHCs to furnish telehealth services to beneficiaries in their home. Medicare would reimburse for these telehealth services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. It would also exclude the costs associated with these services from both the FQHC prospective payment system and the RHC all-inclusive rate calculation.

Sec. 3705. Eliminates a requirement during the COVID-19 emergency period that a nephrologist conduct some of the required periodic evaluations of a patient on home dialysis face-to-face, allowing these vulnerable beneficiaries to get more care in the safety of their homes.

Sec. 3706. Allows qualified providers, including nurse practitioners and physician assistants, to use telehealth technologies in order to fulfill the hospice face-to-face recertification requirement.

Sec. 3707. Requires HHS to issue clarifying guidance encouraging the use of telecommunications systems, including remote patient monitoring, to furnish home health services consistent with the beneficiary care plan during the COVID-19 emergency period.

Sec. 3708. Allows physician assistants, nurse practitioners, and other professionals to order home health services for beneficiaries, reducing delays and increasing beneficiary access to care in the safety of their homes.

Sec. 3709. Temporarily lifts the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020. The Medicare sequester would be extended by one year beyond current law to provide immediate relief without worsening Medicare's long-term financial outlook.

Sec. 3710. Increases the diagnosis-related group (DRG) payment that would otherwise be made to a hospital for treating a patient admitted with COVID-19 by 20 percent. It would build on the CDC decision to expedite use of a COVID-19 diagnosis to enable better surveillance as well as trigger appropriate payment for these complex patients. This add-on payment would be available through the duration of the COVID-19 emergency period.

Sec. 3711. Provides acute care hospitals flexibility, during the COVID-19 emergency period, to transfer patients out of their facilities and into alternative care settings. Specifically, this section would waive the Inpatient Rehabilitation Facility (IRF) 3-hour rule and would allow a Long-Term Care Hospital (LTCH) to maintain its designation even if more than 50 percent of its cases are less intensive. It would also temporarily pause the current LTCH site-neutral payment methodology.

Sec. 3712. Prevents scheduled reductions in Medicare payments for durable medical equipment, which helps patients transition from hospital to home and remain in their home, through the duration of COVID-19 emergency period.

Sec. 3713. Enables beneficiaries to receive a COVID-19 vaccine in Medicare Part B with no cost-sharing.

Sec. 3714. Requires Medicare Part D plans provide up to a 90-day supply of a prescription medication if requested by a beneficiary during the COVID-19 emergency period.

Sec. 3715. Allows state Medicaid programs to pay for direct support professionals, caregivers trained to help with activities of daily living, to assist disabled individuals in the hospital to reduce length of stay and free up beds.

Sec. 3716. Clarifies a section of the Families First Coronavirus Response Act of 2020 (Public Law 116-127) by 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.

Sec. 3717. Clarifies a section of the Families First Coronavirus Response Act of 2020 (Public Law 116-127) by ensuring that beneficiaries can receive all tests for COVID-19 in Medicare Part B with no cost-sharing.

Sec. 3718. Prevents scheduled reductions in Medicare payments for clinical diagnostic laboratory tests furnished to beneficiaries in 2021. It would also delay by one year the upcoming reporting period during which laboratories are required to report private payer data.

Sec. 3719. Expands an existing Medicare accelerated payment program to ensure hospitals have access to reliable and stable cash flow to help them maintain an adequate workforce, buy essential supplies, create additional infrastructure, and keep their doors open to care for patients. Qualified facilities would be able to request up to a six month advanced lump sum or periodic payment. This advanced payment would be based on net reimbursement represented by unbilled discharges or unpaid bills. Most hospital types could elect to receive up to 100 percent of the prior period payments, with Critical Access Hospitals able to receive up to 125 percent. Finally, a qualifying hospital would not be required to start paying down the loan for four months and would also have at least 12 months to complete repayment without a requirement to pay interest.

Sec. 3720. Amends a section of the Families First Coronavirus Response Act of 2020 (Public Law 116-127) to ensure that states are able to receive the Medicaid 6.2 percent FMAP increase.

Sections 3801 through 3832 of the CARES Act address the extension of the Medicare and Medicaid Extenders that were due to expire on May 22, 2020. The bill extends all provisions, including the Medicaid Disproportionate Share Hospital (DSH) delay, through November 30, 2020.