HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

March 27, 2020

Summary of CARES Act Healthcare Provisions

The Coronavirus Aid, Relief, And Economic Security (CARES) Act was passed by the Senate on 3/25 and by the House of Representatives on 3/27. President Trump is expected to sign the bill into law as soon as it reaches his desk.

Below is a summary of the bill's provisions that affect the healthcare system.

Supporting America's Health Care System

***NOTE** – many of these provisions are time limited. Where noted in the law, we have highlighted the expiration date of the benefit/program.*

Coverage for COVID-19 Testing

All Health Plans are currently required to cover FDA approved COVID-19 diagnostic testing. The bill expands the definition for what types of COVID-19 diagnostic tests health plans must cover to include tests for which the developer has submitted or intends to submit an emergency use authorization to the FDA or if the state government where the test was developed notifies HHS that it will review and approve the test. Health plans cannot charge cost sharing for COVID-19 testing. Finally, HHS is authorized to issue guidance that lists tests that health plans must cover.

If health plans do not have an in-network rate for COVID-19 testing with a provider (regardless if the provider is in or out-of-network), the health plan is to pay the provider's list price for the test. Providers that offer COVID-19 testing are required disclose their list price for COVID-19 testing publicly online. If a provider doesn't publicize their testing price online, then the health plan and provider can negotiate the price. Providers can be fined up to $300 per day that they do not publicly list their testing price.

Health plans will also be required to cover approved vaccines for the coronavirus. Approved vaccines must either receive an A or B rating from the U.S. Preventive Services Task Force (USPSTF) or receive a recommendation from the CDC's Advisory Committee on Immunization Practices.

Liability Protection for Volunteer Health Workers
Volunteer health care professionals are protected from liability under Federal or State law for any harm caused by an act or omission in the provision of health care services related to COVID-19 during the public health emergency. Volunteer providers are still required to practice within the scope of their license or certification.

Treatment of Protected Health Information
Within six months, HHS must issue guidance on how to treat Protected Health Information (PHI) with respect to COVID-19.

Health Savings Accounts for Telehealth Services
This section would allow 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.

Over-the-Counter Medical Products without Prescription
This section would allow 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.

Expanding Medicare Telehealth Flexibilities
This section would eliminate the requirement 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

Allowing Federally Qualified Health Centers and Rural Health Clinics to Furnish Telehealth in Medicare
This section would allow, during the COVID-19 emergency period, Federally Qualified Health Centers and Rural Health Clinics 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.

Expanding Medicare Telehealth for Home Dialysis Patients
This section would eliminate 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 home.

Allowing for the Use of Telehealth during the Hospice Care Recertification Process in Medicare
Under current law, hospice physicians and nurse practitioners cannot conduct recertification encounters using telehealth. This section would allow, during the COVID-19 emergency period, qualified providers to use telehealth technologies in order to fulfill the hospice face-to-face recertification requirement.

Encouraging the Use of Telecommunications Systems for Home Health Services in Medicare
This section would require the Health and Human Services (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.

Enabling Physician Assistants and Nurse Practitioners to Order Medicare Home Health Services
This section would allow 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 home.

Increasing Provider Funding through Immediate Medicare Sequester Relief
This section would temporarily lift the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020, boosting payments for hospital, physician, nursing home, home health, and other care. The Medicare sequester would be extended by one-year beyond current law to provide immediate relief without worsening Medicare's long-term financial outlook.

Medicare Add-on for Inpatient Hospital COVID-19 Patients
This section would increase the 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 Centers for Disease Control and Prevention (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.

Increasing Medicare Access to Post-Acute Care
This section would provide acute care hospitals flexibility, during the COVID-19 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 section would waive the Inpatient Rehabilitation Facility (IRF) 3-hour rule, which requires that a beneficiary be expected to participate in at least 3 hours of intensive rehabilitation at least 5 days per week to be admitted to an IRF. It 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.

Preventing Medicare Durable Medical Equipment Payment Reduction
This section would prevent scheduled reductions in Medicare payments for durable medical equipment, which helps patients transition from hospital to home and remain in their home, through the length of COVID-19 emergency period.

Eliminating Medicare Part B Cost-Sharing for the COVID-19 Vaccine
This section would enable beneficiaries to receive a COVID-19 vaccine in Medicare Part B with no cost-sharing.

Allowing Up to 3-Month Fills and Refills of Covered Medicare Part D Drugs

This section would require that 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.

Providing Home and Community-based Support Services during Hospital Stays
This section would allow 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.

Clarification Regarding Uninsured Individuals
This section would clarify a section of the Families First Coronavirus Response Act of 2020 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.

Clarification Regarding Coverage of Tests
This section would clarify a section of the Families First Coronavirus Response Act of 2020 by ensuring that beneficiaries can receive all tests for COVID-19 in Medicare Part B with no cost-sharing.

Preventing Medicare Clinical Laboratory Test Payment Reduction
This section would prevent 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.

Providing Hospitals Medicare Advance Payments
This section would expand, for the duration of the COVID-19 emergency period, an existing Medicare accelerated payment program. Hospitals, especially those facilities in rural and frontier areas, need 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.

Specifically, 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.

Providing State Access to Enhanced Medicaid FMAP
This section would ensure that states are able to receive the previously approved Medicaid 6.2 percent FMAP increase.

Extension of Physician Work Geographic Index Floor
This section would extend increased payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average through December 1, 2020.

Extension of Funding Outreach and Assistance for Low-Income Programs
This section would extend funding for beneficiary outreach and counseling related to low income programs through November 30, 2020.

Extension of Money Follows the Person Demonstration Program
This section would extend the Medicaid Money Follows the Person demonstration that helps patients transition from the nursing home to the home setting through November 30, 2020.

Extension of Spousal Impoverishment Protections
This section would extend the Medicaid spousal impoverishment protections program through November 30, 2020 to help a spouse of an individual who qualifies for nursing home care to live at home in the community.

Delay of Disproportionate Share Hospital Reductions
The section would delay scheduled reductions in Medicaid disproportionate share hospital payments through November 30, 2020.

Extension and Expansion of Community Mental Health Services Demonstration
This section would extend the Medicaid Community Mental Health Services demonstration that provides coordinated care to patients with mental health and substance use disorders, through November 30, 2020. It would also expand the demonstration to two additional states.

Extension of Demonstration Projects to Address Health Professions Workforce Needs
This section extends the Health Professions Opportunity Grants (HPOG) program through November 30, 2020 at current funding levels. This program provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs.