CARES Act (H.R. 748)
Overview of Hospital Provisions

The CARES (Coronavirus Aid, Relief and Economic Security) Act was passed by the U.S. Senate on March 25. **The IHA-supported legislation includes significant funding and support for hospitals and health systems, totaling over $100 billion. Below is a high-level summary of key hospital and healthcare-related provisions.**

The U.S. House of Representatives will consider the bill tomorrow and the White House has signaled that President Trump will quickly sign the measure into law. Note: several provisions in the CARES Act are broadly written and/or require additional details from the Executive Branch regarding accessing and applying for specific funding and other policy measures. Please check www.team-iha.org for the latest information.

$100 Billion in Emergency Funding: Emergency funding will be made available to hospitals and other eligible healthcare providers through the Public Health and Social Services Emergency Fund to "prevent, prepare for, and respond to coronavirus." Funds will be available to reimburse providers, through grants or other payment mechanisms, for healthcare-related expenses or lost revenues not otherwise reimbursed and directly attributable to COVID-19. Funds will be distributed through "the most efficient payment systems practicable to provide emergency payment."

- Eligible Providers: public entities, Medicare- or Medicaid-enrolled providers, and other non-profit and for-profit entities specified by the Secretary of U.S. Department of Health and Human Services (HHS).
- Eligible Expenses: building or construction of structures (including retrofitting); medical supplies and equipment, including personal protective equipment; testing; workforce and training; and surge capacity.
- Application Process: eligible entities must apply for the funding once detailed information is available from HHS, and the application must justify the provider's need for funds. *Please note: Hospitals and health systems are urged to maintain documentation of COVID-19 related expenses, as the application process will require reports and documentation as determined by the Secretary.* IHA will provide detailed information on the application process and requirements as soon as they are made available.

Suspension of Medicare 2% Sequester: Medicare sequester will be suspended from May 1 – December 31, 2020.

20% Medicare DRG Add-On Payment for COVID-19 Cases: The add-on payment will be made during the emergency period and is available for both rural and urban inpatient prospective payment system (IPPS) hospital COVID-19 patients.

Elimination of Medicaid disproportionate share hospital (DSH) program cuts. Fiscal Year (FY) 2020 DSH cuts will be eliminated, and cuts in FY 2021 will be reduced from $8 billion to $4 billion.

Expansion of the Medicare Hospital Accelerated Payment Program: The bill expands and modifies the existing Medicare Hospital Accelerated Payment Program during the emergency period. In addition to IPPS hospitals, critical access hospitals (CAHs), children's hospitals and cancer hospitals may apply. Eligible providers are able to request accelerated payment for inpatient services that cover a time period of up to six months.

- Accelerated Payment Amount: up to 100% (up to 125% for CAHs) of what the hospital would otherwise have received, an increase over the current amount of 70%.
- Repayment: Recoupment would begin after four months (via claims offset). Hospitals have at least 12 months for total repayment.

Post-acute care provisions: This bill waives the long-term care hospital (LTCH) 50 percent rule and site-neutral payment policy during the emergency period. The inpatient rehabilitation facility (IRF) 3-hour rule is also waived.

Telehealth:

- Elimination of 3-Year Rule: This bill eliminates the requirement that health professionals must have treated a patient within the previous 3 years in order to provide telehealth services during the emergency period.
- Enhances Medicare telehealth services for FQHCs and RHCs: during the emergency period, federally qualified health centers (FQHCs) and rural health clinics (RHCs) may serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. **A Section 1135 emergency declaration waiver is required for this provision to take effect.** Reimbursement rates will be comparable to telehealth services under the Medicare Physician Fee Schedule.
- HRSA Telehealth and Rural Health Activities: $275 million will be provided to the Health Resources and Services Administration (HRSA) to support services and activities, including $180 million specified for telehealth and rural health activities.

Increasing Access to Supplies: $27 billion will be provided through FY 2024 to fund activities such as developing vaccines; and purchasing vaccines, diagnostics and surge capacity; workforce modernization; access to telehealth; and other preparedness and response activities. At least $250 million of these funds must be available to entities that are part of the Hospital

Preparedness Program. $16 billion of these funds must be used to support the Strategic National Stockpile.

Other Provisions:

- Sharing of Substance Use Disorder (SUD) Records with Patient Consent: Following a patient's written consent, records pertaining to SUD treatment or other activities may be used or disclosed to covered entities for the purposes of treatment, payment or healthcare operations as permitted by HIPAA.
- Small Business Loans through the Paycheck Protection Program: Loan opportunities will be available to organizations with fewer than 500 total employees. These loans may be up to $10 million and may be forgivable. Both for-profit and non-profit hospitals will be eligible, however, there are limits for those affiliated with larger organizations.

Coverage:

- COVID-19 Testing: Expands the types of diagnostic tests that are covered without cost-sharing.
- Expanded Diagnostic Tests: Covered diagnostic tests include laboratory tests that have not been approved by the Food and Drug Administration (FDA) but meet certain conditions. Additionally, commercial payers and public programs must cover this broader range of tests.
- Diagnostic Test Payment: Health plans are to pay laboratory service providers the full negotiated rate or, in the absence of a negotiated rate, the cash price for the service.
- Covered Preventive Services: Health plans must cover items and services recommended by either the US Preventive Services Task Force or the CDC's Advisory Committee on Immunization Practices.

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