American Hospital Association™
Advancing Health in America

Legislative Update

March 22, 2020

Senate Majority Leader Introduces the Coronavirus Aid, Relief, and Economic Security (CARES) Act

Bill would provide financial resources for individuals, families and small businesses affected by COVID-19, as well as make several key policy changes impacting health care providers

Senate Majority Leader Mitch McConnell has introduced the Coronavirus Aid, Relief, and Economic Security Act, (CARES/ S. 3548). This bill is the third large-scale congressional effort in response to the novel coronavirus (COVID-19) outbreak. Please note that this current Senate legislative language does not reflect a bipartisan agreement at this time. It is expected that negotiations will continue among congressional leaders and the administration. House Speaker Nancy Pelosi also has suggested that the House Democrats may release their own package to reflect their priorities.

The AHA encourages you to work with your senators and representative as this bill keeps developing. Please see our March 19 Alert and our letter with the American Medical Association and American Nurses Association for specifics.

Key Takeaways

Among other health care-related provisions, the package would:

- Increase funding to the Public Health and Social Services Emergency Fund by almost $88 billion to, among other things, reimburse hospitals for COVID-19 expenses;
- Create a Medicare add-on payment of 20% for inpatient hospital COVID-19 patients;
- Remove the Medicare sequester from May through December 2020;
- Delay Medicaid disproportionate share hospital cuts by two years;
- Provide flexibility to post-acute care providers, including waiving the inpatient rehabilitation facility 3-hour rule;
- Take steps to improve the supply chain, including access to masks and drugs, among other items;
- Take steps to expand coverage for COVID-19 testing and testing-related services; and
- Provide new telehealth flexibilities.

The legislation includes a number of provisions to provide financial relief and resources to individuals, families and businesses particularly hard hit by the COVID-19 public health emergency.

The following Advisory provides information on the key provisions directly 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.

HIGHLIGHTS OF PROVISIONS RELEVANT TO HOSPITALS & HEALTH SYSTEMS

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

- $75 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 would be distributed through grants or other mechanisms and would remain available until expended.
- $12.7 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 would fund workforce modernization, telehealth access and other preparedness and response activities. At least $500 million of these funds must be made available to entities that are part of the Hospital Preparedness Program, with $200 million of these funds being made available within 30 days of enactment. In addition, at least $1.7 billion of these funds must be used to purchase products for the Strategic National Stockpile.
- $275 million to remain available until Sept 30, 2022, for the following services administered under the Health Resources and Services Administration (HRSA), of which:
    - $180 million would 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.

Support for Health Care Professionals. The bill would provide funding, grants and other authority to help ensure an adequate workforce, including:

- Reauthorizing HRSA grants related to telehealth and rural health;
- Liability protections for volunteer health care professionals; and
- Establishing a Ready Reserve Corps to help ensure the supply of doctors and nurses trained to respond to public health emergencies.

Medicare Payment Improvements and Flexibilities. The bill seeks to provide additional funds to providers caring for Medicare beneficiaries. Specifically, it would:

- Eliminate the Medicare sequester from May 1 through Dec. 31, 2020;
- During the emergency period, provide a 20% add-on to the diagnosis-related group (DRG) rate for patients with COVID-19. This add-on would apply to patients treated at inpatient prospective payment system (PPS) hospitals;
- Provide 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 receive at least three hours of therapy a day, the "preponderance" of which must be one-on-one;

- Directing the HHS Secretary to exercise enforcement discretion regarding the requirement that long-term care hospitals (LTCHs) have no more than 50% of Medicare cases paid at the site-neutral rate; and
- Directing the HHS Secretary to exercise enforcement discretion regarding allowing all patients admitted to an LTCH due to the emergency to be paid the full LTCH PPS rate.

Medicare and Medicaid Extenders. The legislation would extend a number of Medicare and Medicaid programs.

Medicaid Disproportionate Share Hospital (DSH). The legislation would delay the implementation of the Medicaid DSH cuts by two years but extend cuts for three additional years (through 2028).

Extension of Work Geographic Practice Cost Index (GPCI). This provision would extend the floor on the physician work geographic adjustment factor through calendar year 2021. It is currently set to expire after May 22, 2020.

Extension of Other Medicaid Program. It also would extend the Money Follows the Person demonstration program, spousal impoverishment protections, and the Certified Community Behavioral Health Clinics demonstration program (with two additional states participating) through Sept. 20, 2021.

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

Face-to-Face Visits between Home Dialysis Patients and Physicians. This provision would 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 would 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 supports state funding for training and consulting with providers in rural and underserved areas on treating COVID-19 and other public health emergencies.

Telehealth. The legislation would 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 would 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 – would be to give the HHS Secretary authority to waive, among others, 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 would 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 would be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation would reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule.

Access to Health Care Supplies. The legislation would 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 would amend the Public Health Service Act to require that certain medical supplies and drugs be included in the strategic national stockpile. Specifically, it would 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 would 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 would require certain types of medical supplies be included in the SNS and would 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 would require additional manufacturer 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 would 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 would be covered are those that are life-supporting, life-sustaining, used in

emergency medical care or during surgery. The list would be made publicly available unless otherwise determined by the HHS Secretary and would include relevant information about the device and the reason for the shortage.

Coverage of COVID-19 Testing and Other Services. The legislation would 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 would expand the types of diagnostic tests that would be covered to include laboratory tests that have not been approved by the Food and Drug Administration 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 to cover this broader range of tests, as well as some forms of public coverage. It remains unclear if the Medicare and Medicaid programs are required to cover these additional tests.

Health plans are directed to pay providers' 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 would 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:

Blood Supply Awareness Campaign. The legislation would 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 would 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. It would not, however, change which employees employers could exempt from such policies.

Sharing of Substance Use Disorder Records with Patient Consent. This section would 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 would allow disclosures of de-identified health information from these records to public health authorities as defined by HIPAA. The section would 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 would have the right to request restrictions on the use or disclosure of their SUD treatment records. Finally, this section would require an update to the regulations in no less than one year so that covered entities would be required to provide notice in plain language on their privacy practices to patients.

Occupational Safety and Health Administration (OSHA) Requirements. Notably, the legislation does not contain a provision that had been in previous versions that would have directed the Secretary of Labor, working through OSHA, to develop temporary standard for protection of health care workers from COVID-19 that would have differed from CDC's guidance. CDC is recommending enhanced droplet precautions and the OSHA requirements would have been based on guidance developed to protect workers from airborne spread. Further, the Secretary of Labor was directed to create permanent standards based on this same theory of airborne spread after consulting with those representing health care workers and health care delivery organizations as well as other relevant federal agencies. These disparate directives would have created a great deal of confusion.

FURTHER QUESTIONS

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