

# Key Provisions in the CARES Act for Health Care Providers

Mar 30 2020

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On March 27, 2020 the President signed into law the Coronavirus Aid, Relief, and Economic Security Act, also called the CARES Act, which was previously passed by Congress. The Act contains two main Divisions, each of which includes provisions of key interest to health care providers. A summary of these health care-related provisions follows.

## **Division A: Keeping Workers Paid and Employed, Health Care System Enhancement, and Economic Stabilization**

Division A provides various forms of assistance for workers, families and businesses; supports the American health care system and workforce in the fight against the coronavirus; and offers stabilization for severely distressed sectors of the economy. Significant health care provisions in this Division address telehealth, coverage and testing, HIPAA/substance abuse record privacy, liability protections for volunteers, rural providers, support for the health care work force, Medicaid (including DSH payments), and long term care.

### **Telehealth**

Section 3703 of the Act eliminates a provision in the Coronavirus Preparedness and Response Supplement Appropriations Act that limited the Medicare telehealth expansion during the COVID-19 emergency period to situations where the physician or other professional treated the patient in the last three years. The bill provides for further expansion of telehealth for qualified health centers and rural health clinics (§ 3704), home dialysis patients (§ 3705), and for hospice recertifications (§ 3706). The bill also requires HHS to issue guidance to encourage the use of telecommunications, including remote patient monitoring, and to further home health services during the emergency period (§ 3707). Additional information on the expansion of Medicare telemedicine benefits through waivers previously issued by CMS can be found [here](#).

### **Coverage and Testing Provisions**

The Act temporarily lifts the Medicare sequester which reduced payments to providers by 2% in 2020 (§ 3709). Moreover, the Act increases the Medicare payment made to a hospital for an inpatient stay for a patient with COVID-19 by 20% (§ 3710). This provision builds on the CDC decision to expedite use of a COVID-19 diagnosis to enable better surveillance and facilitation of appropriate payment.

The Act also expands the existing Medicare accelerated payment program (§ 3719). Qualified facilities will be able to request up to a six-month lump sum or periodic payment. Further, hospitals receiving accelerated payments would not be required to start paying down the loan for four months and would have at least twelve months to complete the repayment without interest.

Finally, the Act provides that all testing for COVID-19 is to be covered by private insurance plans without cost-sharing and requires insurers to pay providers either the negotiated rate in effect before the public health emergency or, if there is no such negotiated rate, the cash price posted by the provider on its public internet website (§ 3202). The Act requires providers to make public the cash price for such test on its public internet website. Additionally, the Act eliminates cost-sharing for COVID-19 vaccines for Medicare beneficiaries and requires private insurers to cover COVID-19 vaccines, when they become available, without cost-sharing (§3203).

### **Substance Abuse Record Privacy**

Section 3221 of the CARES Act addresses the ability of substance abuse treatment facilities to use and disclose health information. Patients may now give a single consent for all future uses and disclosures of health information related to the treatment facility's treatment, payment, and health care operations (as such terms are defined in the Health Insurance Privacy and Portability Act of 1996 ("HIPAA")). Other HIPAA provisions and definitions have been specifically incorporated into the statute relating to substance use disorder records, including clarifying that HIPAA's de-identification provisions directly apply to disclosure of these records to public health authorities and that HIPAA breach provisions apply to such records. The prohibitions on using these records in investigations and proceedings have been expanded to expressly include various types of proceedings of governmental agencies regardless of whether or not they involve the individual in question.

A new anti-discrimination provision has been enacted that applies to all entities that may come into contact with substance abuse records. Any such entity shall not discriminate against an individual based on those records in the context of any of the following: provision of health care, employment matters, housing, and access to governmental institutions, benefits, and services.

Finally, section 3224 of the Act directs the Secretary of Health and Human Services to provide ongoing guidance regarding HIPAA and uses and disclosures of health information related to COVID-19 and the declared national emergencies.

### **Limitation on Liability for Volunteer Health Care Professionals**

The Act contains protections for health care professionals under state and federal law for any harm caused by an act or omission of the professional in the provision of health care services as a volunteer during the public health emergency with respect to COVID-19. In order to qualify for these protections, the volunteer professional must be:

- Acting within the scope of the license, registration, or certification of the volunteer, as defined by the state of licensure, registration, or certification;
- Not exceeding the scope of license, registration, or certification of a substantially similar health professional in the state in which such act or omission occurs; and
- Acting in a good faith belief that the individual being treated is in need of health care services.

These protections do not apply if the harm was caused by an act or omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed by the health care professional; or if the health care professional rendered the health care services under the influence (as determined pursuant to applicable State law) of alcohol or an intoxicating drug.

This section of the Act preempts the laws of a state or any political subdivision of a state to the extent that such laws are inconsistent with this section, unless those laws provide greater protection from liability.

Finally, these protections are not retroactive; they only apply to harm occurring on or after the date of enactment. They are also subject to a sunset, remaining in effect only for the length of the public health emergency declared by the DHHS Secretary.

## **Rural Providers**

The Act amends the federal Public Health Services Act (42 U.S.C. 254c) (PHSA) in areas relating to rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs. These include the following:

- The Director of the Office of Rural Health Policy is now authorized to award grants expanding access to, coordinating and improving the quality of “basic” (rather than just “essential”) health care services.
- Grants may be awarded for periods up to five years (previously three years).
- Previously, grant eligibility was limited to rural public or rural nonprofit private entities; this has been revised to cover entities “with demonstrated experience serving, or the capacity to serve, rural underserved populations.”
- The Act authorizes appropriations of \$79 million per fiscal year from 2021 through 2025, up from \$45 million/year under the previous authorization.

## **Health Care Work Force**

The Act reauthorizes certain health professions workforce programs under the PHSA and addresses coordination of the health workforce. It also provides for education and training relating to geriatrics as well as nursing workforce development.

Section 3401 contains various appropriation authorizations. For example, the Act authorizes an appropriation of \$23,711,000 per fiscal year for grants and contracts with health professional schools and other public and nonprofit health and educational entities for the purpose of assisting the schools in supporting programs of excellence in health professions education for under-represented minority individuals (Centers of Excellence). The appropriation covers fiscal years 2021 through 2025. The Act also provides funding for scholarships to disadvantaged students in the amount of \$51,470,000 per fiscal year for that same time frame.

Under section 3402, the DHHS Secretary is required to consult with the Advisory Committee on Training in Primary Care Medicine and Dentistry and the Advisory Council on Graduate Medical Education, on the development, within one year of enactment, of a comprehensive and coordinated plan with respect to the health care workforce development programs of the Department of Health and Human Services, including education and training programs. The plans are required to include (a) performance measures to determine the extent to which those programs are strengthening the nation’s health care system; (b) identify any gaps that exist between the outcomes of those programs and projected health care workforce needs, and (c) identify actions to address the gaps and barriers, if any, to implementing those actions.

The DHHS Secretary is also required coordinate with the heads of other federal agencies and departments that fund or administer health care workforce development programs, including education and training programs, to (a) evaluate the performance of those programs, including the extent to which the programs are efficient and effective and are meeting the nation’s health workforce needs; and (b) identify opportunities to improve the quality and consistency of the information collected to evaluate within and across those programs, and to implement those improvements.

Section 3403 revises the Public Health Service Act by authorizing the DHHS Secretary to award grants, contracts, or cooperative agreements to approved health professions schools or programs and other entities for the establishment or operation of Geriatrics Workforce Enhancement Programs. Supported activities include clinical training on providing integrated geriatrics and primary care delivery services; interprofessional training on the care of older adults; and education on Alzheimer’s disease and related dementias. Grants can be for up to five years, with priority given to programs or activities that expected to substantially benefit rural or medically underserved populations of older adults, or which serve older adults in Indian Tribes or Tribal organizations. Section 3403 also directs the DHHS Secretary to establish or maintain a program to provide geriatric academic career awards to promote the career development of individuals as academic geriatricians or other academic geriatrics health professionals.

Finally, section 3404 makes significant changes under Title VII of the PHSA regarding nursing workforce development. It creates a new eligibility classification under the PHSA for health clinics that (a) are managed by advanced practice nurses; (b) provide primary care or wellness services to underserved or vulnerable populations; and (c) are associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency. Advanced education nursing grants are expanded to include a new category for “clinical nurse specialist” programs, while nurse education, practice and quality grants are expanded to include nurse retention. The Act also authorizes appropriations for nursing workforce development for fiscal years 2021 through 2025 in the amount of \$137,837,000 per year. Finally, the Act requires the Comptroller General to conduct an evaluation of the nurse loan repayment programs administered by the Health Resources and Services Administration and report back to Congress on that evaluation, which may include recommendations to improve relevant nursing workforce loan repayment programs.

### **Medicaid**

The CARES Act expands Medicaid coverage in a variety of ways in response to the public health emergency.

- The Money Follows the Person program, a program that assists seniors and persons with disabilities transition from institutional settings, is extended with additional funding through the end of November 2020.
- The spousal impoverishment protections relating to Medicaid eligibility are extended as well through the end of November 2020, allowing states to broaden eligibility requirements disregarding spousal income.
- The Act delays scheduled reductions in Medicaid Disproportionate Share Hospital (DSH) payments through November 30, 2020 and provides for an increase in 6.2% of the Federal Medical Assistance Percentage (FMAP).
- Finally, the Act extends the Community Mental Health Services Demonstration Project for the eight states already participating and requires the HHS Secretary to select two additional states in the next six months to participate in two-year demonstration projects to operate community behavioral health clinics.

### **Long Term Care**

The CARES Act eases the regulatory burdens relating to a variety of post-acute care services during the emergency period.

Section 3711 waives requirements for certain post-acute care facilities, effectively increasing access to these facilities during the emergency period and allowing the facilities greater flexibility in the treatment they provide. Inpatient rehabilitation facilities (“IRFs”) typically must provide a patient a minimum of 3 hours of intensive rehabilitation therapy per day for at least 5 days per week to qualify for Medicare reimbursement. The Act waives this requirement, allowing IRFs to admit and retain more patients and generally provide fewer hours of therapy during the emergency period.

Section 3711 also relaxes some reimbursement adjustments during the emergency period for long term care hospitals (“LTCHs”) including (1) waiving the “50 percent rule” that adjusts reimbursement to LTCHs that do not have a discharge payment percentage of at least 50% and (2) waiving the site-neutral payment rate for a discharge if admission occurred during the emergency period and in response to the public health emergency.

Finally, section 3715 allows Medicaid to pay acute care hospitals to provide patients home and community based services provided the services to smooth the transition between the hospital and the patient’s home and community based setting (such as an assisted living) and to preserve the individual’s functional abilities.

## **Division B: Emergency Appropriations for Coronavirus Health Response and Agency Operations**

Division B contains supplemental appropriations for various branches and agencies of the federal government. Key appropriations for the Department of Health and Human Services are found in Title VIII of Division B. DHHS appropriations under Title VIII include funding for the Centers for Disease Control and Prevention, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, the Administration for Children and Families, and the Administration for Community Living. Of particular interest to health care providers is the appropriation of funds to the DHHS Secretary for a Public Health and Social Services Emergency Fund (the "Fund").

Congress has appropriated \$27 billion for the Fund, to remain available until September 30, 2024, to prevent, prepare and respond to coronavirus. Purposes of this appropriation include "the development of necessary countermeasures and vaccines, prioritizing platform-based technologies with U.S.-based manufacturing capabilities, the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, as well as medical surge capacity, addressing blood supply chain, workforce modernization, telehealth access and infrastructure, initial advanced manufacturing, novel dispensing, enhancements to the U.S. Commissioned Corps, and other preparedness and response activities." Not less than \$250,000,000 of this amount will be available for grants or cooperative agreements under the Hospital Preparedness Program, which among other things promotes regional collaboration on health care preparedness and response through the funding of Health Care Coalitions with health care organizations.

The Fund may also be used for grants for the construction, alteration, or renovation of non-federally owned facilities to improve preparedness and response capability at the state and local level; and for the construction, alteration, or renovation of non-federally owned facilities for the production of vaccines, therapeutics, and diagnostics.

Significantly, Title VIII of Division B appropriates an *additional \$100 billion* for the Fund to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses *to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus*. These grants are subject to the following:

- "Eligible health care providers" means public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities as the DHHS Secretary may specify, within the United States (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.
- Funds will be available for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.
- The funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.
- To be eligible for a payment under this paragraph, an eligible health care provider must submit to the DHHS Secretary an application that includes a statement justifying the need of the provider for the payment and the provider's tax identification number.
- The term "payment" means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the DHHS Secretary.
- Payments will be made in consideration of the most efficient payment systems practicable to provide emergency payment.
- Recipients of payments under this paragraph must submit reports and maintain documentation as the DHHS Secretary determines are needed to ensure compliance with conditions that are imposed for such payments, and such reports and documentation shall be in such form, with such content, and in such time as the Secretary may prescribe for such purpose.

We anticipate that DHHS will be issuing further guidance on eligibility and the application process relative to these grants under the Fund.

Title VIII of Division B includes various other General Provisions relating to DHHS. For example, the DHHS Secretary is required to provide a detailed spend plan of anticipated uses of funds made available to DHHS under the Act, including estimated personnel and administrative costs, to the House and Senate Committees on Appropriations no later than 30 days after enactment of the Act. The Secretary must submit updated spend plans every 60 days until September 30, 2024. The spend plans must be accompanied by a listing of each contract obligation incurred that exceeds \$5,000,000.

In addition, the General Provisions require that any laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19 must report the results from each such test to the DHHS Secretary until the end of the Secretary's Public Health Emergency declaration with respect to COVID-19 or any extension of that declaration. The DHHS Secretary may prescribe which laboratories must submit reports pursuant to this section.

### **Conclusion**

The CARES Act will have far-reaching effects on the health care industry that extend beyond the immediate and short-term responses to COVID-19. Many details remain to be worked out, such as the process by which health care providers may apply for grants to cover health care related expenses or lost revenues that are attributable to coronavirus. We will continue to update the industry on these impacts and opportunities as additional guidance becomes available.

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