

Coronavirus: Q&A related to health care and the health care system

HOSPITALS AND HEALTH SYSTEM

What financial assistance is available for hospitals, health systems and health care providers in the bill?

One of the primary ways the bill supports our health system is a \$100 billion fund, run through the Public Health and Social Services Emergency Fund (PHSSEF), to cover non-reimbursable expenses attributable to Covid-19. All health care entities that provide health care, diagnoses or testing are eligible for funding. Additional funding mechanisms, such as Medicare payment boosts, support for community health centers and additional appropriated funding, are discussed in more detail below.

What is the process and criteria for hospitals, health systems and health care providers to receive the PHSSEF funding?

The \$100 billion PHSSEF fund is designed to be immediately responsive to needs. HHS is instructed to review applications and make payments on a rolling basis, in order to get money into the health system as quickly as possible. This is in contrast to a more traditional competitive grant process, under which HHS would solicit applications by a certain deadline and review all applications together – a process that would take considerably more time. HHS will instead release the funds to health care entities on a rolling basis as qualified applications are received. As such, HHS is given significant flexibility in determining how the funds are allocated, as opposed to operating under a mandated formula or process for awarding the funds. This is to ensure that the funding is nimble enough to meet all needs and that the fund disperses money fast enough to help struggling entities. The Secretary is expected to release guidance on the application process shortly, and Congress will continue to work with the Administration to ensure that the funding and application process works as intended.

What expenses qualify for funding?

All non-reimbursable expenses attributable to Covid-19 qualify for funding. Examples include building or retrofitting new ICUs, increased staffing or training, personal protective equipment, the building of temporary structures and more. Forgone revenue from cancelled procedures, which has put significant strain on the health care system, is also a qualified expense. It is important to note that this fund can only be used for non-reimbursable expenses. Any expenses reimbursed or obligated to be reimbursed by insurance or other mechanisms are not eligible. The bill instructs the Secretary to establish a reconciliation process under which payments will have to be returned to the fund if other sources provide reimbursement for expenses.

Can health care entities access funds under the PHSSEF if they are also eligible for funding from another government program?

Yes. The language states that the funds may not be used for expenses or losses that have been reimbursed from other sources or that other sources are *obligated* to reimburse. Even if qualified expenses are *eligible* for reimbursement from another mechanism, an entity may still apply for funding from the PHSSEF fund while simultaneously applying for funding from other sources. However, should the entity subsequently receive reimbursement for expenses from any other source after receiving funding for the same expenses from the PHSSEF fund, the entity will be required to re-pay the funding it received from the PHSSEF fund. This same principal also applies to the new SBA7(a) loans Paycheck Protection Program forgivable loans, the SBA's Economic Injury Disaster Loan (EIDL) Program, and the new EIDL Emergency Grant Program..

What is the process for hospitals, health systems and health care providers to apply for and receive funding under the 7(a) SBA Paycheck Protection Program?

Small businesses and 501(c)(3) non-profit organizations, including hospitals, health systems, and health care providers, are eligible to apply for the Small Business Administration's Paycheck Protection Program. Through this program, a small business or organization can apply to an SBA-approved lender for a loan of up to 250% of your average monthly payroll costs to cover eight weeks of payroll as well as help with other expenses like rent, mortgage payments, and utilities. This loan can be forgiven based on maintaining employee and salary levels. For any portion of the loan that is not forgiven, the terms include a maximum term of 10 years, a maximum interest rate of 4 percent. Small businesses and organizations will be able to apply if they were harmed by COVID-19 between February 15, 2020 and June 30, 2020. To be eligible, small businesses and 501(c)(3) non-profit organizations must have fewer than 500 employees, or more if SBA's size standards for the non-profit allows. This program is retroactive to February 15, 2020, in order to help bring workers who may have already been laid off back onto payrolls. Loans are available through June 30, 2020.

What support is included for community health centers?

The Coronavirus Aid, Relief, and Economic Security Act provides \$1.32 billion in supplemental funding for community health centers (CHCS), which are on the front lines in addressing COVID-19 in underserved communities across the country. This funding is in addition to the \$100 million distributed by the Health Resources and Services Administration (HRSA) to CHCs on March 24th. Community Health Centers can also access the PHSEFF fund.

If I have private insurance, will I have to pay for a coronavirus test?

The Families First Coronavirus Act required that all private insurance plans cover coronavirus testing without deductibles, coinsurance, or co-pays. That bill also prohibited plans from using tools like prior authorization to limit access to testing. The CARES Act makes a technical correction to ensure that the policy covers all tests that meet the appropriate standards. Insurers also have to cover fees for visits to the ER, an urgent care center, or a doctor's office associated with getting a test without cost sharing.

If I have private insurance, how does this bill affect the cost of a vaccine when one becomes available?

The Affordable Care Act required that preventive services and vaccines be covered by private insurance without cost-sharing. Normally, these services and vaccines are covered starting on the first day of the plan year beginning after they get a favorable rating or recommendation from the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices. This section requires that coverage without cost sharing begin fifteen days after getting a favorable rating or recommendation.

MEDICARE

How does this bill increase access to telehealth services for seniors and other Medicare beneficiaries?

The CARES Act gives the Secretary of Health and Human Services (HHS) broad authority to allow more health care providers to provide telehealth services to Medicare beneficiaries, including in the beneficiaries' homes to avoid potential exposure to COVID-19, and provide more flexibility in terms of how those telehealth services can be provided. Once enacted into law, the HHS Secretary must put out guidance explaining how this expanded waiver authority will be used to increase access to telehealth services for seniors and other Medicare beneficiaries.

I've heard from Federally Qualified Health Centers (FQHCs) (including Community Health Centers (CHCs)) and Rural Health Clinics (RHCs) that the Administration won't allow them to use telehealth and get paid. Does this bill help those providers deliver care via telehealth?

Yes. The CARES Act requires the HHS Secretary to provide Medicare payment to FQHCs (including CHCs) and RHCs for telehealth services provided to seniors and other Medicare beneficiaries, including in the beneficiaries' homes to avoid potential exposure to COVID-19, during the COVID-19 public health emergency. Medicare would be required to pay the FQHC or RHC at rates similar to those for telehealth services provided from a doctor's office. Costs associated with those telehealth services would not affect the prospective payment system for FQHCs or the all-inclusive rates for RHCs.

How does this bill help clinical laboratories when it comes to Medicare?

The CARES Act prevents scheduled Medicare payment cuts for clinical diagnostic laboratory tests furnished to Medicare beneficiaries in 2021. It also delays by one year—until 2022—the upcoming reporting period during which laboratories are required to report private payor data.

How much will patients have to pay for the COVID-19 vaccine once it becomes available?

The CARES Act ensures that the vaccine itself and its administration is free to beneficiaries with Medicare Part B and those with Medicare Advantage who receive the vaccine from an in-network provider.

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How will seniors access the medications they need while also being told it's better to stay at home? In the past, Medicare drug plans only let beneficiaries receive a 30 day supply of their prescription.

Under the CARES Act, during the COVID-19 Public Health Emergency (PHE) a senior on Medicare can get up to 90 days of a prescription if that is what the doctor prescribed, as long as there are no safety concerns. Medicare drug plans will also allow beneficiaries to fill prescription early for refills up to 90 days, depending on the prescription.

Hospitals are facing cash flow challenges due to canceling elective services. Is there anything in this bill to help hospitals stay afloat, even temporarily?

The COVID-19 emergency has created significant cash flow concerns for many hospitals. Hospitals need reliable and stable cash flow to help them maintain and support their workforce, buy essential supplies, create additional infrastructure, and keep their doors open to care for patients. During the COVID-19 public health emergency (PHE), the CARES Act creates the opportunity for hospitals to receive accelerated payments. Specifically, acute care hospitals, critical access hospitals (CAHs), children's hospitals, and prospective payment system-exempt cancer hospitals (PCHs) will be able to request accelerated Medicare payments for inpatient hospital services. This is an expanded set of hospitals compared with the existing accelerated payment program.

Rather than waiting until claims have been processed to issue payment, Medicare will work with qualified and interested hospitals to estimate their upcoming payments and give that money to the hospital in advance. Qualified facilities can request a lump sum or periodic payment reflecting up to six months of Medicare services. Accelerated payments must be repaid to Medicare, however a qualifying hospital would not be required to start paying Medicare back for four months after receiving the first payment. Hospitals would have at least 12 months to complete repayment without paying interest.

Hospitals interested in receiving accelerated payments should contact their Medicare Administrative Contractor (MAC). To learn which MAC to contact, please look [here](#).

Does the bill give additional flexibility for hospice providers?

Yes. In order for a qualified beneficiary to receive hospice benefits, a hospice physician or nurse practitioner must certify their eligibility. Typically, a recertification must be done in person. The CARES Act allows hospice physicians and nurse practitioners to conduct these visits via telehealth for the duration of the PHE.

Many hospitals are concerned that there aren't enough ICU beds to take care of those with COVID-19, and inpatient rehabilitation hospitals (IRF) and long-term care hospitals (LTCH) are trying to help build capacity. However, current rules and regulations won't allow them to take certain patients. What does The CARES Act do to help?

The CARES Act makes changes to both IRFs and LTCHs to provide hospitals with more flexibility when discharging patients in order to maximize bed capacity. It also opens up existing beds at IRFs and LTCHs to increase the availability of post-acute services.

Currently, in order to be admitted to an IRF, Medicare patients must be expected to participate in at least three hours of intensive rehabilitation at least five days per week (also known as the “three-hour rule”). The CARES Act waives this requirement so that IRFs have the ability to accept more patients who may otherwise be sent to other post-acute facilities, such as nursing homes.

Patients who are admitted to LTCHs usually must meet certain clinical criteria for an LTCH to receive a higher Medicare payment. If less than half of an LTCH's patients meet these criteria, they are no longer eligible to receive any LTCH payments. The CARES Act waives both of these policies for the duration of the PHE so that LTCHs may accept as many patients as necessary at their LTCH rate, without regard to the clinical criteria. By waiving these criteria, an LTCH will be able to take more patients from an acute care hospital and still get paid.

With more patients needing to stay at home, and a growing concern over health care workforce shortages due to COVID-19, how does The CARES Act help those who depend on the home health benefit?

Under current law, only physicians are able to certify the need for home health services. The CARES Act makes a permanent, statutory change to allow physician assistants, nurse practitioners, and clinical nurse specialists to order home health services for beneficiaries, reducing delays and increasing beneficiary access to care in the safety of their home.

The CARES Act also directs the Secretary of Health and Human Services (HHS) to encourage the use of telecommunications systems, including remote patient monitoring, to deliver home health services consistent with the beneficiary care plan during the COVID-19 emergency period. This allows patients to receive certain home health services without a provider entering their home.

Treating patients with COVID-19 is very resource intensive for hospitals. How will Medicare ensure that hospitals are adequately reimbursed for treating COVID-19 patients?

The CARES Act increases Medicare reimbursement to care for a COVID-19 patient by 20 percent (specifically, the Act increases the weighting factor of DRGs for inpatients diagnosed with COVID-19 by 20 percent). This add-on payment for inpatient hospital services recognizes the increased costs incurred by providers and will be applied for the duration of the COVID-19 emergency.

If a hospital has not treated any cases of COVID-19, are there other ways it can benefit from the Medicare policies in the bill?

Yes. The CARES Act temporarily lifts the Medicare sequester, effectively adding an additional two percent for services provided from May 1 through December 31, 2020. This will boost payments for hospital, physician, nursing home, home health, and other care, giving prompt economic assistance to health care providers that treat Medicare patients.

If a patient has COVID-19 and has to enter the hospital, can their regular personal care attendant, who they depend on at home, still help while the patient is in the hospital?

Under the CARES Act, state Medicaid programs now have the ability, should they choose to pick up the option, to allow direct support professionals to continue to provide care and services for patients they are supporting in the hospital, including seniors and individuals with disabilities.