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Health Care Provider Relief under the CARES Act and PPPHCEA: Supporting Those on the Front Lines of the Fight against COVID-19

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This is an update to our Client Alert posted on March 30, 2020.

Less than a month after passing the $2.0 trillion Coronavirus Aid, Relief, and Economic Security Act of 2020 (the "CARES Act"), Congress has passed and the President has signed a second round of aid (the Paycheck Protection Program and Health Care Enhancement Act, the "PPPHCEA") that stakeholders in the health care industry can use to continue the fight against COVID-19 and stay in business until social distancing orders are loosened. Below is a summary of the various sources of funding and other health care related provisions that health care providers and suppliers can take advantage of as part of both the CARES Act and the PPPHCEA.

Public Health and Social Services Emergency Fund

The CARES Act authorized the U.S. Department of Health and Human Services ("HHS") to directly cover costs of hospitals, health systems and other providers related to COVID-19; the bill earmarked $100 billion for this purpose. $30 billion was initially allocated for payment as part of the Public Health and Social Services Emergency Fund (the "Provider Relief Fund") with an additional $20 billion released starting April 24, 2020 as part of the general allocation; HHS has also announced targeted allocations which include supporting hospitals in areas hardest hit by the pandemic, ensuring treatment for uninsured individuals, and protecting rural providers and the Indian Health Service. The PPPHCEA includes an infusion of an additional $75 billion to the Provider Relief Fund.

General Allocation

The initial $30 billion of generally allocated funds was delivered via direct deposit to eligible providers between April 10, 2020 and April 17, 2020, with an additional $20 billion being delivered on a rolling basis staring on April 24, 2020. Within 30 days of receiving such payments, which were issued as grants with no repayment obligations, providers were required to log onto the CARES Act Provider Relief Fund Payment Attestation Portal and execute an attestation confirming receipt of the funds and agreeing to the terms and conditions provided by HHS (the "Terms and Conditions") found here.

Providers should be cautious in agreeing to the Terms and Conditions, as HHS Secretary Alex Azar stressed that HHS, including the Office of Inspector General will audit and pursue significant fraud to ensure that funds are appropriately distributed. "Congress has entrusted us with an immense amount of money to send to providers and we will be clear and careful about how we're doing it," Azar said during a press call on Wednesday afternoon.

To be eligible to receive the initial payment under the Provider Relief Fund, providers must have received Medicare fee-for-service ("FFS") reimbursements in 2019, have treated "individuals with possible or actual cases of COVID-19" after January 31, 2020, and agree not to seek collection of out-of-pocket payments from a "presumptive or actual" COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. HHS has interpreted "possible or actual" COVID-19 patients, which eligible providers must have treated after January 31, 2020, to include any patient seen after January 31, 2020. It is not clear if that interpretation will apply to "presumptive or actual" COVID-19 patients, the language used in the patient charge limitation provision. It is noteworthy that, in setting the requirements for the above-noted limitation on patient charges, HHS first said that it applied, again, to "possible or actual" COVID-19 patients (which, as noted, meant all patients). When providers noted that this charge limitation was too broad, HHS revised the application of the limitation to "presumptive or actual" from "possible or actual" COVID-19 patients. As of this writing, it is not clear how HHS will apply the "presumptive or actual" COVID-19 patient language in the limitation.

HHS calculated the amount paid to each eligible provider by determining the portion of the total $484 billion of 2019 FFS that the provider billed, and multiplying that percentage against the initial $30 billion distribution; the calculated amount was then paid to billing organizations based on their Taxpayer Identification Number. In updated guidance, HHS clarified that the total share of the $50 billion disbursed from the Provider Relief Fund was to be based on each eligible provider's share of 2018 net patient revenue, and the additional $20 billion that will begin to be distributed April 24, 2020 should augment each provider's allocation to align with 2018 net patient revenue. This shift from FFS payments to net patient revenue across all sources was flagged by HHS as a better indicator of the size of provider entities and should ensure that money is more equitably shared among providers. Entities with adequate cost report information on file with CMS will automatically receive payment starting on April 24, 2020, while providers with inadequate cost report information will need to submit revenue numbers through a portal provided by HHS.

Other Terms and Conditions provided by HHS include a number of certifications that the eligible provider must attest to in order to retain the payment, including the following:

1. Provider billed Medicare in 2019;
2. Provider is not currently terminated from Medicare;
3. Provider is not currently excluded from Medicare, Medicaid or any other Federal health care program;
4. Provider does not have its Medicare billing privileges revoked;
5. Provider will only use the payment to prevent, prepare for, and respond to COVID-19;
6. Provider will use the payment to reimburse provider for health care related expenses or lost revenues attributable to COVID-19; and
7. Provider will not use the payment to reimburse expenses or losses for which the provider has received reimbursement from another source.

In addition, HHS has specified that the grants issued under the Provider Relief Fund cannot be used to pay salary in excess of $197,300 for any individual.

As the payments were sent directly to providers without any affirmative action, providers who are ineligible for the Provider Relief Fund grants must contact HHS and return the money within 30 days of receipt; a failure to promptly return the money will be deemed an agreement to the Terms and Conditions.

Targeted Allocations

In addition to generally allocating funds, HHS announced targeted allocations to help both COVID-19 patients certain types of hospitals providing care for infected individuals. Starting on April 27, 2020, providers who have treated uninsured COVID-19 patients on or after February 4, 2020 can register for reimbursement at Medicare rates. Providers can start submitting claims in early May 2020 and should begin to receive reimbursement in mid-May. Additional details regarding this program can be found here.

As for hospitals treating COVID-19 patients, $10 billion has been earmarked by HHS to be distributed to hospitals in locales that have been disproportionately impacted by the COVID-19 pandemic; hospitals in such areas were contacted directly by HHS and required to provide the hospital's tax identification number, national provider identifier, total number of ICU beds as of April 10, 2020, and total number of admissions with positive diagnosis for COVID-19 between January 1, 2020 and April 10, 2020. An additional $10 billion will be allocated to rural health clinics and hospitals, while $400 million will be allocated for Indian Health Service facilities, each on the basis of operating expenses of such facilities. HHS also stated that additional allocations may be made to non-hospital providers, including skilled nursing facilities, dentists and providers that solely take Medicaid.

Medicare Advance Payments

The CARES Act expanded provider and supplier eligibility to allow CMS to provide advance/accelerated Medicare payments under the existing Accelerated and Advance Payment Program. For the duration of the COVID-19 pandemic, providers and suppliers may request advance/accelerated Medicare payments so long as the entity in question (1) has billed Medicare for claims within 180 days of the request, (2) is not in bankruptcy, (3) is not under an active medical review or program integrity investigation, and (4) has no outstanding delinquent Medicare payments. Eligible providers and suppliers may apply for advance/accelerated Medicare payments through the applicable Medicare Administrative Contractor (MAC) website, and should expect to receive payment within seven days of the MAC's receipt of the request.

The vast majority of provider and suppliers are eligible for 100% of the provider or suppliers Medicare payment for three months; inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are eligible for a six-month advance at 100%, while critical access hospitals are eligible for a six-month advance at 125%. Unlike the grants provider by HHS under the Provider Relief Fund, the advance/accelerated payments must be repaid, with inpatient acute care hospitals, children's hospitals, certain cancer hospitals and critical access hospitals needing to repay within one (1) year of receipt of the advance/accelerated payment, and all other provider and suppliers needing to repay the amounts within 210 days of receipt. Guidance for filling out the request form can be found in the Fact Sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers during COVID-19 Emergency.

Other Hospital-Specific Financial Relief

In addition to tranches of money set aside for the health care industry and advance/accelerated Medicare payments, hospitals can also benefit from adjustments to reimbursement amounts from federal health care programs, including a 20% add-on Medicare payment to hospitals treating patients infected by COVID-19, a 6.2% increase in matching funds from the federal government for Medicaid patients, Medicare sequester relief and delay of scheduled decreases in Medicaid disproportionate share payments. State Medicaid programs are also authorized under the CARES Act to compensate trained caregivers for providing services during hospital stays to lower the capacity burden on hospitals by decreasing the length of stay for disabled individuals.

Funding Generally Available to Health Care Providers and Other Small Businesses

Loan Programs Provided by the SBA

The CARES Act includes two separate avenues, the Paycheck Protection Program (the "PPP") and Economic Injury Disaster Loans ("EIDLs"), through which the U.S. Small Business Administration (the "SBA") is authorized to provide low interest rate loans to small businesses. Health care providers looking to maintain their pre-COVID-19 business by avoiding layoffs and other reductions in operating expenses as revenue drops during long periods of government-imposed social distancing may be eligible to receive these loans.

The Paycheck Protection Program

Congress initially authorized approximately $350 billion to the PPP as part of the CARES Act. Within three weeks of the PPP's creation, loans for the entire $350 billion were distributed to small businesses, including sole practitioners and small medical practices, leading Congress to allocate an additional $310 billion to the PPP as part of the PPPHCEA. For more details on the PPP, including details regarding the SBA's recent statements limiting publicly-traded company's eligibility to receive PPP loans, please refer to Proskauer's up-to-date guide here.

Emergency Economic Disaster Loans

Providers who exceed the size criteria for the PPP may be eligible for emergency EIDLs provided by the SBA, for which the CARES Act initially set aside $10 billion, and allocated an additional $10 billion as part of the PPPHCEA. EIDLs are low-interest working capital loans of up to $2.0 million that may be used to pay existing debt, payroll, accounts payable and other bills that cannot be paid by borrowers due to COVID-19. The CARES Act expands eligibility for EIDLs through December 31, 2020 to include sole proprietors, independent contractors and private non-profits. Corporate borrowers must fall below the size benchmarks set forth by the SBA to qualify for EIDLs, which includes average annual revenue of $41.5 million for General Medical and Surgical Hospitals or Specialty Hospitals, $30.0 million for Skilled Nursing Facilities, $16.5 million for Home Health Care Services, and $12.0 million for Assisted Living Facilities for the Elderly and Offices of Physicians; thresholds for other health care providers are provided on the SBA's website. Non-profits that qualify for EIDLs can receive loans with interest rates of 2.75%; other eligible providers can receive loans with interest rates of 3.75%.

Main Street Lending Program

In order to support small and mid-sized businesses that were in good standing prior to the COVID-19 pandemic, the Federal Reserve announced a $600 billion lending program (the "Main Street Lending Program"), which may be available to providers who do not qualify for EIDLs or loans under the PPP. Entities with fewer than 15,000 employees and less than $5.0 billion in 2019 annual revenue may be eligible to participate in the Main Street Lending Program. For more information on the Main Street Lending Program, please refer to Proskauer's client alert here.

Telemedicine

The CARES Act includes a number of telehealth measures that expand the ability of providers and patients to interact remotely and encourage social distancing practices. In addition to reauthorizing of the Health Resources and Services Administration (HRSA) grant program, which will promote the use of telehealth delivery of health care services, the CARES Act expands access for Medicare enrollees to telehealth from a broader range of providers (eliminating the requirement that the individual had been treated by the provider within the last 3 years), and authorizes and encourages Federally Qualified Health Centers ("FQHCs") to provide care through telehealth by providing reimbursement pursuant to the Medicare Physician Fee Schedule, eliminates certain face-to-face requirements for the delivery of home dialysis and hospice care recertification, and encourages the use of telehealth by home health providers. It should be noted that CMS has provided for an even broader expansion of telehealth under its emergency waiver authority.

Physician and Practice Group-Specific Provisions

While physicians and practice groups can seek financial recompense through the SBA and by applying for advance/accelerated Medicare payments as set forth above, in order to encourage that all available health professionals participate in the national response to COVID-19, the CARES Act ensures that physicians providing medical services on a volunteer basis have protection from liability incurred pursuant to the delivery of such services and establishes a Ready Reserve Corps comprised of trained practitioners for response both to COVID-19 and other future public health emergencies..

FQHC Relief

In addition to encouraging FQHCs to provide care via telehealth, the CARES Act initially allocated $1.3 billion in emergency supplemental funding to be provided by HHS for community health centers, including federally-qualified health centers; an additional $600 million is included in the PPPHCEA. These amounts are in addition to extending mandatory funding already available to FQHCs through November 2020.

Provisions Related to Post-Acute Care Providers

Congress also sought to leverage post-acute care providers to address limitations on bed capacity at hospitals by providing more flexibility in the event a hospital's ability to find space for patients is exceeded. The CARES Act attempts to offset the burden of treating non-COVID-19 patients by allowing acute care facilities to move patients to post-acute care setting through waiver of the 3-hour rule for admission into Inpatient Rehabilitation Facilities and elimination of the requirement that Long Term Care Hospitals must have at least 50% of its admissions be intensive care patients. The CARES Act also includes measures to soften the transition from hospitals and post-acute care facilities to home treatment by eliminating a scheduled reduction in Medicare payments for DME for the duration of the national health emergency, making it more affordable for patients to convalesce while at home.

Conclusion

Ultimately, the CARES Act provided some relief for health care providers, but as evidenced by the PPPHCEA, continued growth of COVID-19 cases and on-going social distancing orders will continue to require further action by the Federal government to help support the surge in capacity needed to provide care and protect economically both hospitals who are providing the immediate response to the epidemic and other providers who are unable to provide services and thus may go out of business as communities engage in social distancing.

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