Key Physician Provisions

Coronavirus Aid, Relief, and Economic Security (CARES) Act
The Coronavirus Aid, Relief, and Economic Security (CARES) Act had a series of provisions, which may be of interest to physicians. The final bill text is [here](#), with the appropriations summary (Division B) from Republicans [here](#) and Democrats [here](#), unemployment/retirement summary [here](#), Finance Committee health provisions summary [here](#), HELP Committee summary [here](#), HELP Committee one pager [here](#), Small Business Committee summary [here](#), and one pager [here](#).

Paycheck Protection Program and Health Care Enhancement Act
The Paycheck Protection Program and Health Care Enhancement Act added $75 billion to the CARES Act Provider Relief Fund.

Key Provisions

Small business relief
There are four main provisions to provide relief to physicians, physician practices, and (in some instances) physician professional organizations:

1. Paycheck Protection Program;
2. CARES Act Provider Relief Fund;
3. Accelerated and Advance Payments through Medicare; and
4. Loans, loan guarantees, and other investments under the Coronavirus Economic Stabilization Act.

Paycheck Protection Program
*Paycheck Protection Program* (PPP) provides a loan of up to $10 million or 250% of the average monthly payroll to help assist small businesses (with less than 500 employees) with salaries (and related expenses) and certain other items. Loan payments will be deferred for at least six months. If you maintain your workforce and retain appropriate salary levels, the Small Business Administration (SBA) may forgive a portion of the loan proceeds that are used to cover the first eight weeks of payroll and certain other expenses following loan origination.¹ For more information, visit [here](#) (SBA resource), [here](#) (Hart Health resource), and [here](#) (Hart Health FAQ).

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¹ Under section 1106, the bill details a process by which first an entity receives a loan, and then an entity can apply for loan forgiveness for certain business expenses, with certain restrictions related to any reduction in the number of employees. Once the SBA has confirmed those amounts and other necessary information, then within 90 days, the SBA pays the lender confirmed business expense amount or the amount of the loan, whichever is less.

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**CARES Act Provider Relief Fund**

Division B of the **CARES Act** includes key language related to an initial $100 billion for health care services related to the COVID-19. Specifically, the funds are “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.” 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.

The **Paycheck Protection Program and Health Care Enhancement Act** added $75 billion to the **CARES Act Provider Relief Fund**.

**HHS Announcements**

On April 3, during the Task Force press conference, Secretary Azar noted that a portion of the $100 billion provided to the Public Health and Social Services Fund for health care providers in the **CARES Act** would be allocated to cover the cost of the treatment for the uninsured. Such funding would be through the same mechanism as COVID-19 testing. As a condition of receiving the funds, providers would have to agree not to balance bill, and the reimbursement rates would be set at Medicare rates. The Secretary further noted that additional specifics regarding the rest of the funds would be forthcoming.

On April 7, CMS Administrator Seema Verma noted that $30 billion of the $100 billion fund through the PHSSEF for health care providers, $30 billion will be available via grants, based on Medicare revenue, and such funds will NOT be on a first come, first serve basis. To receive the funds, providers will need to register with CMS. Money can be direct deposited. She acknowledged that certain providers (e.g., pediatricians, OB/Gyns, etc.) do not serve a large portion of the Medicare population. As such, CMS will address those issues in the second wave of funding from the fund. During that announcement, there was no discussion regarding the uninsured.

On April 10, HHS issued information regarding the $30 billion, including a press release, a fact sheet, and Terms and Conditions. Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. Many health care providers received the funds on April 10. Within 30 days of receipt of the funds, a provider must attest to receiving the funds and agree to the Terms and Conditions. Otherwise, the provider needs to contact HHS and then remit the full payment as instructed. HHS has subsequently clarified that not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions. In addition, the House Ways and Means Committee Republicans issued information, including a fact sheet, FAQ, and information on the amount of funds to each State.

On April 16, the **CARES Act Provider Relief Fund Payment Attestation Portal** went live. The portal has a variety of steps, including confirmation of eligibility, billing TINs, verifying payment information, attestations (likely related to the Terms and Conditions), and confirmation.

To assist with distributing the funds, HHS has contracted with UnitedHealth Group. For questions regarding the distribution of funds, please call the toll-free CARES Provider Relief line at 866-569-3522.

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2 Key language begins on p. 750.
3 The Terms and Conditions have been updated at least twice – on April 13 and April 20. Therefore, the ensuing discussion focuses on the latest Terms and Conditions. However, these Terms and Conditions have changed and may change again.
On April 22, HHS provided additional information regarding the disbursement of funds, as detailed in the chart below.

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Funding allocation</th>
<th>Formula</th>
<th>Distribution Timeline</th>
<th>Additional processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Allocation</td>
<td>$50 B</td>
<td>$30 B proportionately based on Medicare FFS in 2019</td>
<td>April 10 ($26 B) – 17 ($4B)</td>
<td>On April 24, a portion of providers will automatically be sent an advance payment based off the revenue data they submit in CMS cost reports. Providers without adequate cost report data on file will need to submit their revenue information to a portal opening this week linked on this page for additional general distribution funds. Providers who receive their money automatically will still need to submit their revenue information so that it can be verified. Payments will go out weekly, on a rolling basis, as information is validated, with the first wave being delivered at the end of this week (April 24, 2020). Providers who receive funds from the general distribution have to sign an attestation confirming receipt of funds and agree to the terms and conditions of payment and confirm the CMS cost report. The Terms and Conditions also include other measures to help prevent fraud and misuse of the funds. All recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus. There will be significant anti-fraud and auditing work done by HHS, including the work of the Office of the Inspector General.</td>
</tr>
<tr>
<td>“Hot Spots”</td>
<td>Initial $10 B</td>
<td>Proportionately based on total number of Intensive Care Unit beds as of April 10, 2020, and total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020, along with a DSH adjustment.</td>
<td>Likely April 27</td>
<td>Hospitals should apply for a portion of the funds by providing four simple pieces of information via an authentication portal before 3:00 PM Eastern Time, Saturday, April 25. This portal is live, and hospitals have already been contacted directly to provide this information. The authentication and data-sharing process should take less than five minutes via a system that should be familiar to most hospitals. This information is necessary for the government to determine what facilities will qualify for a targeted distribution. Supplying this information does not guarantee receipt of funds from this distribution. The Administration will use the data it receives to distribute the targeted funds to where the impact from COVID-19 is greatest. The distribution will take into consideration the challenges faced by facilities serving a significantly disproportionate number of low-income patients, as reflected by their Medicare Disproportionate Share Hospital (DSH) Adjustment.</td>
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<tr>
<td>Rural providers</td>
<td>$10 B</td>
<td>Proportionately based on operating expenses</td>
<td>Starting April 26</td>
<td>This money will be distributed as early as next week on the basis of operating expenses, using a methodology that distributes payments proportionately to each facility and clinic. This methodrecognizes the precarious financial position of many rural hospitals, a significant number of which are unprofitable. Rural hospitals are more financially exposed to significant declines in revenue or increases in expenses related to COVID-19 than their urban counterparts.</td>
</tr>
<tr>
<td>Indian Health</td>
<td>$400 M</td>
<td>Proportionately based on operating expenses</td>
<td>April 24</td>
<td>Recognizing the strain experiences by the Indian Health Service, $400 million will be allocated for Indian Health Service facilities, distributed on the basis of operating expenses. Indian Country is also being impacted by COVID-19.</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Dependent on claims received; $10 B*</td>
<td>Based on claims; paid at Medicare rates</td>
<td>Registration starting April 27</td>
<td>As announced in early April, a portion of the $100 billion Provider Relief Fund will be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured. Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding.</td>
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4 HHS delayed the timeframe per the April 23 press release here.
Steps will involve: enrolling as a provider participant, checking patient eligibility and benefits, submitting patient information, submitting claims, and receiving payment via direct deposit. Providers can register for the program on April 27, 2020 and begin submitting claims in early May 2020. For more information, visit https://www.hrsa.gov/coviduninsuredclaim. As a condition, providers are obligated to abstain from “balance billing” any patient for COVID-19-related treatment. For more information on the uninsured portions, see our summary here.

<table>
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<th>Additional allocations</th>
<th>TBD</th>
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<td><strong>There are some providers who will receive further, separate funding, including skilled nursing facilities, dentists, and providers that solely take Medicaid.</strong></td>
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*Not included in HHS’ information but relayed by Hill staff regarding the intent.

**Terms and Conditions for the General Allocation**

In reviewing the **Terms and Conditions**, there are a few key items for providers to consider, as detailed below.

**Possible or Actual cases.** The provider must attest that s/he “provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.” The initial terms and conditions did not include the specific date. While not included in the Terms and Conditions, HHS on its website further noted that “HHS broadly views every patient as a possible case of COVID-19.” With the addition of the date and the HHS clarification, a provider may be able to attest to this requirement if s/he treated any patient after January 31, whether via telehealth or in-person.

**Bans balanced billing.** In essence, to retain the funds, a provider must not balance bill for “all care for a presumptive or actual case of COVID-19.” For those patients, the provider must not seek from the patient more than the patient would have been obligated to pay if the provider was an in-network provider. While it is still unclear which cases would be “presumptive or actual” cases, one could attest that this subset of patients is different from “possible or actual” (which is essentially all patients) but would still apply to all patients in that subset, regardless of payer. And, given that this language does not have a similar date qualifier (i.e., January 31 date), it is unclear when HHS expects the balance billing requirement to be in effect. This is particularly troubling, given that, so far, there’s been no discussion regarding the amount of payment required. It would be good to receive some clarity regarding the application of these terms as well as “all care.”

**No other reimbursement.** One additional requirement is that the “Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.” Unfortunately, HHS did not provide enough information for providers to easily untangle how to provide appropriate accounting for these items, especially given that many healthcare services may be under additional obligations (e.g., Medicare payment for certain telehealth services), interactions with other government programs (e.g., the Paycheck Protection Program), etc.

**Salary cap.** The funds provided cannot be used to “pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” According to OPM, Executive Level II is $197,300.

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5 The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a presumptive or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network Recipient. (Language updated on April 20.)
for 2020. On its website, HHS has stated that “these are payments, not loans” but has not clarified whether this is an “extramural mechanism” subject to this restriction.

**Use of funds.** Another key requirement is that the “Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.” This requirement is confusing at best, and it seems virtually impossible to use the fund *at the same time* for both care and lost revenue. Therefore, additional clarity is needed, especially in light of the extensive reporting requirements for the program. It would be best if the Department of Health and Human Services provided a list of potential items for use with these funds (e.g., PPE, certain payroll costs, non-cash expenses such as depreciation, etc.).

**Not an exhaustive list.** The Terms and Conditions include a statement that “[t]his is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable.” Further, the notice states that “[n]on-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund.”

**Subcontractors.** Another key statement is that “[t]hese Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient, also apply to subrecipients and contractors under grants, unless an exception is specified.” It’s unclear from this statement if subrecipients and contractors who are not paid via grants from the Recipient are similarly restricted.

**Tax status.** The information provided does not make the tax status clear. Therefore, it would be helpful if HHS provided clarity regarding what taxes, if any, should apply to the funds.

**Statutory Summary**

Both the *CARES Act* and the *Paycheck Protection Program and Health Care Enhancement Act* used the same statutory language to describe the fund and the requirements of the fund.
**Definition:** “eligible health care providers” means public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described as the 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.

**Payments.** Directs the Secretary of Health and Human Services to, on a rolling basis, review applications and make payments. The term “payment” means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary. That payments are directed to be made in consideration of the most efficient payment systems practicable to provide emergency payment.

**Use of Funds.** Funds are 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.

**Application process.** An eligible health care provider shall submit to the Secretary of Health and Human Services an application that includes a statement justifying the need of the provider for the payment and the eligible health care provider shall have a valid tax identification number.

**Reports.** Recipients are required to submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with the required conditions.

**Accelerated and Advanced Payments Through Medicare**

Section 3719 of the CARES Act made changes to the Accelerated and Advanced Payments mechanism through Medicare, primarily to provide additional changes to address hospital concerns. CMS launched the amended program on March 28. The program will provide accelerated payments to requesting providers and advance payments to requesting suppliers, including physicians and non-physician practitioners, who submit a request to the appropriate Medicare Administrative Contractor (MAC) and meet the following criteria:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider’s/supplier’s request form,
- Is not in bankruptcy,
- Not be under active medical review or program integrity investigation, and
- Does not have any outstanding delinquent Medicare overpayments.

CMS intends to provide assistance first to those providers and suppliers that experience increased demand and surge in patients. MACs responsible for processing accelerated/advance payment requests for different states, will prioritize those states that were hit the hardest (currently, these states are reported to be California, New York, and Washington). Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period. Based on this formula, qualified providers/suppliers will be asked to request a specific amount using an Accelerated/Advanced Payment Request Document provided on each MAC’s website.

For complete details on the process, please review the following fact sheet.

On April 7, CMS announced that $34 billion had been made available through this program. On April 10, CMS provided a state-by-state analysis of the use of this program, broken down by provider type (i.e., Part A providers and only Part B providers).
Key Considerations

Loan, not grant. The monies provided through this program must be repaid.

Quick repayment terms. For physicians, repayment begins 120 days after the issuance of the payment and ends 210 days from the date of the accelerated or advance payment was made.

Recoupment. At the end of the 120-day period, the recoupment process will begin and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the provider’s/supplier’s outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process is automatic.

Interest Rate. As is statutorily required in the Federal Claims Collection Act, Medicare regulation 42 CFR Section 405.378 provides for the charging and payment of interest on overpayments and underpayments to Medicare providers. The Secretary of Treasury certifies an interest rate quarterly. Treasury utilizes the most comprehensive data available on consumer interest rates to determine the certified rate. Interest is assessed on delinquent debts in order to protect the Medicare Trust Funds. The current interest rate is 10.25%.

Title IV, Subtitle A: Coronavirus Economic Stabilization Act
Section 4003 establishes a key fund for loans, loan guarantees, and other investments for companies with losses tied to the coronavirus pandemic that threaten their continued operation. Of the $500 billion fund, $25 billion is available to airlines, $4 billion to cargo air carriers, and $17 billion for companies “critical to national security”, with the remainder ($454 billion) for everyone else. Until March 1, 2022, companies that receive aid could not increase compensation for executives and other employees who made more than $425,000 in 2019. Any severance pay or other termination benefits paid to those employees during that period could not exceed twice their 2019 compensation.

Additional Key Health Provisions
A list of additional key health provisions is included below.

Appropriations

- **$16 billion to replenish the Strategic National Stockpile** supplies of pharmaceuticals, personal protective equipment, and other medical supplies, which are distributed to State and local health agencies, hospitals and other healthcare entities facing shortages during emergencies.
- **$3.5 billion for BARDA to expand the production of vaccines**, therapeutics, and diagnostics to help combat this pandemic.
- **$1 billion for the Defense Production Act** to bolster domestic supply chains, enabling industry to quickly ramp up production of personal protective equipment, ventilators, and other urgently needed medical supplies.

HELP Committee Provisions

- **Limitation on liability** for volunteer health care professionals during COVID-19 emergency response. Makes clear that doctors who provide volunteer medical services during the public health emergency related to COVID-19 have liability protections. (Section 3215)
- **Requiring the strategic national stockpile to include certain types of medical supplies.** Clarifies that the Strategic National Stockpile can stockpile medical supplies, such as the swabs necessary for diagnostic testing for COVID-19. (Section 3102)
• Treatment of respiratory protective devices as covered counter- measures. Provides permanent liability protection for manufacturers of personal respiratory protective equipment, such as masks and respirators, in the event of a public health emergency, to incentivize production and distribution. (Section 3203)

• Rapid coverage of preventive services and vaccines for coronavirus. Coverage of diagnostic testing for COVID-19. Clarifies that all testing for COVID-19 is to be covered by private insurance plans without cost sharing, including those tests without an EUA by the FDA. (Section 3201 and 3717)

• Pricing of diagnostic testing. For COVID-19 testing covered with no cost to patients, requires an insurer to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider. (Section 3202)

• Telehealth network and telehealth resource centers grant programs. Reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services. (Section 3212)

Finance Committee Provisions

• Increasing Medicare telehealth flexibilities during emergency period. Allows the Secretary to waive the requirements under section 1834(m). (Section 3703)

• Increasing Provider Funding through Immediate Medicare Sequester Relief. Temporarily lifts the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020. The Medicare sequester would be extended by one-year beyond current law to provide immediate relief without worsening Medicare’s long-term financial outlook. (Section 3709)

• Extension of the work geographic index floor under the Medicare program. Extends the floor until December 1, 2020. (Section 3801)

• Amendments relating to reporting requirements with respect to clinical diagnostic laboratory tests. Delays certain reporting requirements and payment adjustments. (Section 3719)