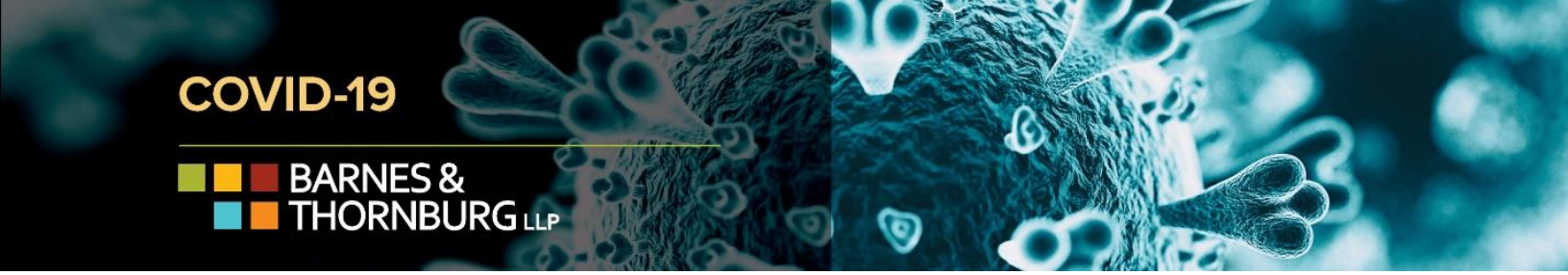

Healthcare FAQs

Updated: April 24, 2020

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CARES ACT

Q: Does the stimulus bill provide relief for healthcare providers and facilities combatting the COVID-19 pandemic?

A: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) includes grants of approximately $150 billion in current and future funding for hospitals related to COVID-19 equipment and treatment. The CARES Act allocates $100 billion to reimburse eligible healthcare providers for healthcare-related expenses and lost revenue attributable to the COVID-19 pandemic, and allocates $16 billion to the Strategic National Stockpile in order to increase the availability of equipment, including ventilators and masks. The CARES Act also provides $11 billion for diagnostics, treatments, and vaccines for COVID-19, as well as $80 million for the FDA to prioritize and expedite approval of new drugs. Further, the CARES Act provides $1.32 billion in immediate additional funding for community centers that serve approximately 28 million people. Additional funding and relief may be offered through state government relief efforts.

Q: How does the CARES Act expand the availability of grants through the Hospital Preparedness Program?

A: The CARES Act allocates $250 million in grants and cooperative agreements for grantees and sub-grantees of the Hospital Preparedness Program under the Public Health Service Act. The Hospital Preparedness Program designates a majority of federal funds toward healthcare facilities, such as outpatient facilities, inpatient facilities, and other entities (e.g., poison control, emergency medical services, nursing), in order to increase preparedness for pandemics, like COVID-19. Specifically, the program is intended to enhance preparedness activities that make the healthcare system more efficient, resilient, and coordinated during epidemics and pandemics.

Q: What is the new eligibility criteria for advanced Medicare payments under the CARES Act?

A: Under the CARES Act, providers and suppliers are eligible for Medicare advanced payment if the provider or supplier: 1) has billed a claim 180 days before the request; 2) is not in bankruptcy; 3) is not under investigation; and 4) does not have any outstanding Medicare overpayments. Most providers

and suppliers are eligible for up to 100 percent of their Medicare payment amounts for a three-month period, though certain facility types are eligible for up to 125 percent of Medicare payment amounts for up to six months. Providers and suppliers are immediately eligible to apply for accelerated or advanced Medicare payments using the Accelerated/Advanced Payment Request form, which is distributed by their Medicare Administrative Contractor. Successfully processed requests will be funded within seven days of receipt.

For more information regarding the CARES Act, see the following BT Alert:

BT Alert: CARES Act Delivers Much-Needed COVID-19 Relief, Assistance To Healthcare Industry

Q: What is the $100 billion healthcare provider fund of the CARES Act and who is eligible to receive these funds?

A: The CARES Act allocates $100 billion to the Public Health and Social Services Emergency Fund, which is intended to provide reimbursement to healthcare providers to "prevent, prepare for, and respond to the coronavirus." Reimbursement may also be available for hospitals that treat uninsured COVID-19 patients.

In order to be eligible for reimbursement, all of the following must be true:

1. The healthcare provider is an eligible type of provider. The CARES Act defines an "eligible" provider that may be entitled to reimbursement under the Fund as "public entities, Medicare or Medicaid enrolled health care providers and suppliers, and other for-profit and not-for-profit entities that provide diagnoses, testing or care for individuals with possible or actual cases of COVID-19."
2. The expenses are necessary. The CARES Act sets forth the following items as necessary expenses entitled to reimbursement under the Fund: construction of temporary premises, leasing property, medical supplies and equipment, increased workforce and training, emergency operation centers, and surge capacity.
3. The expenses or lost revenue is attributable to COVID-19.
4. The expenses or loss is not reimbursable from another source.

In order to access reimbursement under the Fund, eligible providers must complete and submit an application to the Department of Health and Human Service (HHS), along with any reports and documentation as HHS deems necessary. HHS will review applications for funding and provide payment on a rolling basis. Payment may be pre-pay or retrospective reimbursement. On April 3, 2020, Alex Azar, Secretary of HHS, explained that reimbursement will be provided at the Medicare rate and that hospitals who accept this money are prohibited from balance billing the uninsured patients (i.e., billing the patient for the difference between the Medicare rate and the amount the hospital might otherwise charge). Currently there is no further guidance regarding details of the Fund. However, HHS has stated that more details will be forthcoming.

Q: What are common myths regarding the CARES Act's Payment Protection Program (PPP)?

A:

- All of the funding has run out.
    - False. The forgivable nature of the PPP has made it very popular. It is anticipated that this program will run out of money, but the Small Business Administration (SBA) has not announced that it has run out of funding yet. We encourage you to submit your application for PPP assistance immediately. Congress is discussing appropriating more funds to the PPP, but nothing in Washington, D.C. is guaranteed until it successfully crosses the President's desk.

- I am not eligible for a PPP loan.
    - You might be right, but you could be wrong! Have you evaluated this question with your legal or financial counsel? If not, we highly encourage you to review your eligibility with third-party counsel. As explained above, due to the widespread program myths, it is difficult to determine eligibility by reading articles and summaries independently. The government has put out extensive advice on the PPP at different times that has increased and decreased eligibility for PPP funds. Depending on the date of the article or summary you have read, you may believe that you are not eligible for PPP funds when you otherwise are.
- Non-profits are not eligible for a PPP loan.
    - False. The eligible non-profits that can participate in the PPP are 501(c)(3) organizations, 501(c)(19) veterans' organizations, and tribal business organizations. Non-profit organizations that are not tax-exempt under IRC sections 501(c)(3) or 501(c)(19), such as trade associations, advocacy organizations, unions, and social clubs, are not eligible to participate in the PPP.
- My business is already struggling and cannot afford a loan.
    - The PPP funds are designed to help businesses just like yours! Did you know that a portion of the loan is forgivable? The forgivable nature of the loan is directly linked to an employer's retention of employees. Therefore, if you are a small business that can retain or rehire your employees, and you are sustaining losses due to COVID-19, the PPP was created precisely for your business.
- My business is still up and running – I don't think I need the loan.
    - The PPP funds are designed to help companies struggling. When we hear, "My business is doing well, it isn't struggling," we have found this to be a comparative statement, such as "My business is doing much better than other businesses in the region." However, the vast majority of these companies that are still "doing well" are still struggling financially. When determining if you need this loan, do not compare your businesses to others, but instead, compare your current business's profitability and success to how you were doing as a business on February 1, 2020. If you are doing worse today than on February 1, you should review your options under the PPP.
- No way the government is giving away "free money" – what is the catch?
    - True, there is no such thing as "free money" in this world. Instead, the government is returning your tax dollars to you under the PPP through partial or complete loan forgiveness in an amount equal to payroll costs, mortgage interest, rent, or utility costs during the eight weeks following the origination of the loan. The interest on the principle of the loan is not forgivable. Therefore, while the PPP is not "free" money, the forgivable nature of the PPP loan substantially reduces a company's liabilities for repayment.

Q: Are healthcare providers who were required to cancel elective surgical/medical procedures due to COVID-19 eligible to receive a forgivable loan under the CARES Act?

A: Yes, providers are eligible for these loans. However, the amount of the loan will be equal to the lost revenue from postponing or canceling the procedures minus any amount of money the provider recovers under any business loss insurance policy.

Q: Do healthcare providers have to apply for a Medicare Provider Relief Fund payment?

A: No. HHS is automatically making direct payments to all facilities and providers that received Medicare payments in 2019. These "Provider Relief Fund" (PRF) payments ($30 billion in total funds) are best explained on the HHS website here. These payments are automatic (no application needed), but providers must submit a signed attestation confirming receipt of funds and agreeing to the terms and conditions of payment within 30 days of receipt. This payment is not a loan (and thus no repayment is

required) and is not the same as the Accelerated and Advance Payment Program (which requires repayment). The amount of the PRF payment is simply based on the healthcare provider's actual Medicare reimbursement from 2019 compared to all Medicare payments made by CMS in 2019.

TELEHEALTH SERVICES

Medicare Telehealth Coverage

Q: What are the changes to Medicare's telehealth covered benefit?

A: The Coronavirus Preparedness and Response Supplemental Appropriations Act relaxed Medicare's telehealth requirements for services provided from March 6, 2020, until termination of the COVID-19 emergency period. Under this guidance, Medicare will reimburse for services provided to beneficiaries located in any location, including the patient's home, and there is no requirement that the patient be located in a rural health professional shortage area or a non-urban area. Further, telehealth services may be provided through any electronic device with audio and visual capabilities that allows for two-way, real-time interactive communication, including smartphones. Medicare-covered telehealth services include specialized office visits, mental health counseling, and preventive health screenings, and the U.S. Center for Medicare and Medicaid Services (CMS) stated that it will not enforce the requirement that a patient have a pre-existing relationship with a provider in order to receive telehealth services from the provider.

For more information about CMS' relaxed telehealth rules during the COVID-19 pandemic, see the following BT Alert:

BT Alert: Coronavirus Prompts Telehealth Changes for Medicare

Q: Are states and commercial insurance plans implementing similar policies?

A: Many states have issued similar waivers of requirements for telemedicine providers, and most commercial insurance plans provide coverage for telehealth services, during the COVID-19 emergency declaration period.

Q: May providers provide therapy and monitor patients remotely?

A: The federal Food and Drug Administration (FDA) issued guidance expanding the availability and use of FDA-approved non-invasive monitoring devices, such as heart monitors, electronic thermometers, and electrocardiographs (ECGs), and clinical decision support software. Though the guidance is aimed primarily at enabling remote access of patients with suspected or confirmed cases of COVID-19, the guidance specifically states that the FDA also permits the use of these technologies for monitoring patients with other diagnoses and conditions. In addition, CMS removed many restrictions for providing telehealth services, including specialist visits, to Medicare beneficiaries, which allows providers greater flexibility in providing therapy remotely.

Q: May general practitioners conduct evaluation and management visits remotely?

A: CMS relaxed many requirements for coverage of telehealth services under Medicare, and many states and commercial payors have done the same. Under the relaxed policy, Medicare will pay for remote or virtual evaluation and management visits the same as if the visits were in person. As long as a practitioner can communicate with patients using audio and visual telecommunications, the practitioner should be able to conduct these visits remotely, at least during the COVID-19 pandemic.

Q: Are there policies or recommendations for screening patients remotely for COVID-19?

A: The FDA issued guidance expanding the availability and use of FDA-approved non-invasive monitoring devices, such as heart monitors, electronic thermometers, and electrocardiographs (ECGs), specifically for the purpose of enabling remote screening and monitoring of COVID-19 patients. To the extent possible, providers should screen patients with suspected cases of COVID-19 remotely in order to reduce the number of people going in and out of healthcare facilities.

HIPAA AND DATA PRIVACY

Q: What HIPAA requirements have been waived during the COVID-19 pandemic?

A: Beginning on March 15, 2020, the U.S. Secretary of Health and Human Services (HHS) declared a limited waiver of certain HIPAA provisions during limited circumstances related to the COVID-19 pandemic: 1) requirement to obtain a patient's agreement to speak with individuals involved in the patient's care; 2) requirement to honor a request to opt out of the facility directory; 3) requirement to distribute a notice of privacy practices; 4) a patient's right to request privacy restrictions; and 5) a patient's right to request confidential communications.

The HIPAA waivers only apply under the following limited circumstances: 1) in the emergency area identified in the public health emergency declaration; 2) to hospitals that have instituted a disaster protocol; and 3) for up to 72 hours from the time the hospital implements the disaster protocol. The HIPAA Privacy Rule also includes several provisions related to the disclosure of protected health information (PHI) for public health and law enforcement purposes, which may become relevant throughout the COVID-19 pandemic.

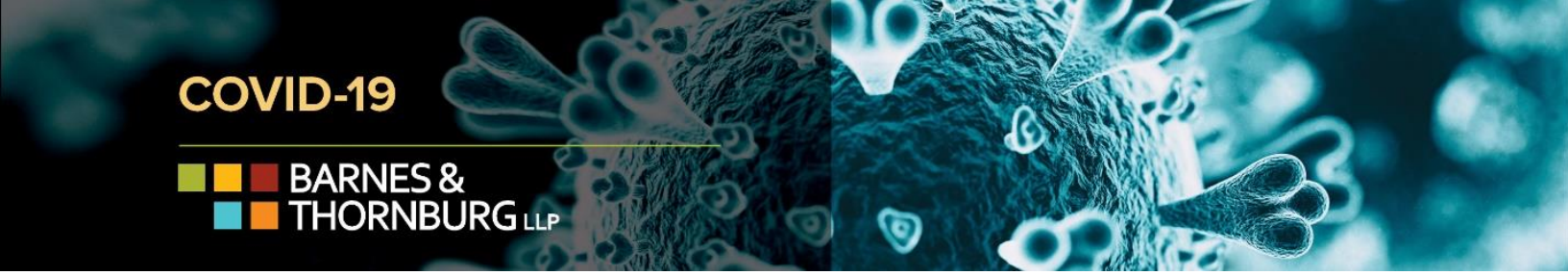
For more information about the HIPAA waivers during the COVID-19 pandemic, see the following BT Alert:

BT Alert: Relaxing of HIPAA Laws During COVID-19 Pandemic

Q: Given the expansion of coverage for telehealth services, how can providers mitigate cybersecurity and data privacy risks?

A: Providing telehealth services under Medicare's relaxed requirements may increase the risks of an unauthorized user intercepting or accessing a patient's health information because providers are permitted to provide services through unencrypted devices. The HHS Office of Civil Rights (OCR), which is responsible for enforcing HIPAA, stated that it will waive penalties under HIPAA for telehealth providers that use unencrypted technology, such as smartphones or Skype, as long as providers make a good faith effort to prevent unauthorized access and/or disclosure of health information.

However, providers should remain vigilant in protecting the privacy and security of health information received, created, or stored in relation to all patient care, regardless of whether services are provided in-person or virtually. Such measures include using a secure Wi-Fi network, accessing records through a virtual privacy network (VPN), encrypting PHI prior to transmitting it, when possible, and moving to a private room or area when providing telehealth services.



PROVIDER PROTECTION/INFECTION PREVENTION

Q: Are there guidelines or recommendations for reusing personal protective equipment (PPE), including N-95 respirators, facemasks, and isolation gowns?

A: Although there is a severe shortage of PPE in hospitals around the country, the CDC has not issued formal guidance or recommendations regarding whether it is safe to reuse PPE and, if so, how to properly sterilize it. However, the CDC's website lists strategies for optimizing the use and life of PPE and equipment, depending on whether a facility is facing "conventional capacity," "contingency capacity" or "crisis capacity." Many hospitals have also published reports of sterilization methods the use to maximize use and reuse of PPE during the COVID-19 pandemic. Healthcare facilities and providers should implement strategies that allow for safe, effective use and reuse of PPE and equipment, without compromising the provider's or patient's health.

Q: Are there any guidelines or recommendations for healthcare provider and staff COVID-19 screening and testing?

A: With the limited number of COVID-19 tests available, healthcare facilities are unable to test all providers and staff that are providing COVID-19-related care, and must therefore rely on other screening methods to determine which providers and personnel should be removed from patient care duties. Further complicating matters is that many people who are infected with COVID-19 do not exhibit any physical symptoms. It is imperative for healthcare facilities to check in with providers and personnel who have been in direct contact with patients diagnosed with COVID-19 to determine whether they may have contracted the virus and are therefore at risk of spreading the virus to other individuals. The CDC recommends categorizing asymptomatic personnel as high-, medium-, and low-risk, depending on the length of close contact a provider had with a COVID-19 patient, as well as the PPE the provider was wearing at the time of the contact. Personnel categorized as high- or medium-risk should be excluded from work for 14 days from the date of the last exposure, whereas personnel categorized as low-risk would not need to have any work restrictions.

Q: Can essential employees in a healthcare facility continue to work after exposure to a COVID-positive individual as long as asymptomatic, or do they need to be quarantined post-exposure for 14 days?

A: If a staff member was exposed to COVID but is not symptomatic, under the CDC guidelines, necessary healthcare providers may continue to work as long as they remain asymptomatic and the staff member must wear a mask at all times. The staff member's symptoms and temperature must be checked at the beginning of each shift.

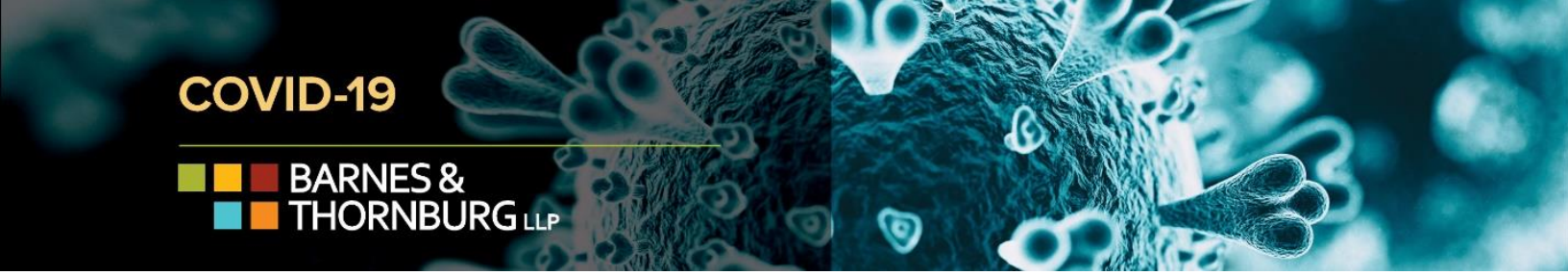
See the CDC risk assessment:

CDC Risk Assessment

COMMUNICATION PLANNING FOR HOSPITALS AND PHYSICIANS

Q: How should healthcare facilities and systems communicate updates regarding COVID-19 to physicians, staff, governing boards and the community at large?

A: Healthcare facilities should communicate as openly and honestly as possible with all of constituents, whenever new information or developments become available. Facilities should work with physicians and staff on a daily basis to ensure all parties have the most up-to-date information and that physicians and staff are getting the supplies and equipment they need, to the extent possible.



PANDEMIC PATIENT CARE PLANNING

Q: What is the impact of the COVID-19 pandemic on hospital admissions and performing elective procedures?

A: Due to the influx of COVID-19-related patient care, many state governors are imposing limitations on the amount of hospital admissions and the types of procedures providers may perform. At this time, many hospitals have eliminated all non-emergent patient admissions in order to preserve bed capacity for COVID-19-related cases. Further, the CDC has recommended postponing all elective procedures and nonessential appointments during the COVID-19 pandemic, in order to conserve resources for COVID-19 patients. Essential appointments are appointments needed for ongoing management of a condition, such as cancer treatments or diabetes management, as well as prenatal appointments. Some state governors have taken the step to prohibit elective procedures.

Q: How should a healthcare facility begin to plan for the potential need to ration resources, such as beds and equipment?

A: Rationing resources, including potentially deciding which patients receive patient care, such as ventilators and even hospital beds, is a last resort that health care facilities may eventually face depending on how long the COVID-19 pandemic lasts. In planning for this contingency, facilities should work with their legal counsel, ethics committee, and governing board in order to determine how patient care and resource allocation decisions will be made, if necessary. Rationing limited resources is a difficult issue that implicates legal and ethical considerations, but it is important to have a plan in advance, rather than scrambling to figure out how to proceed if/when the need arises.

Q: Are ancillary service providers permitted to provide services to residents in long-term care facilities?

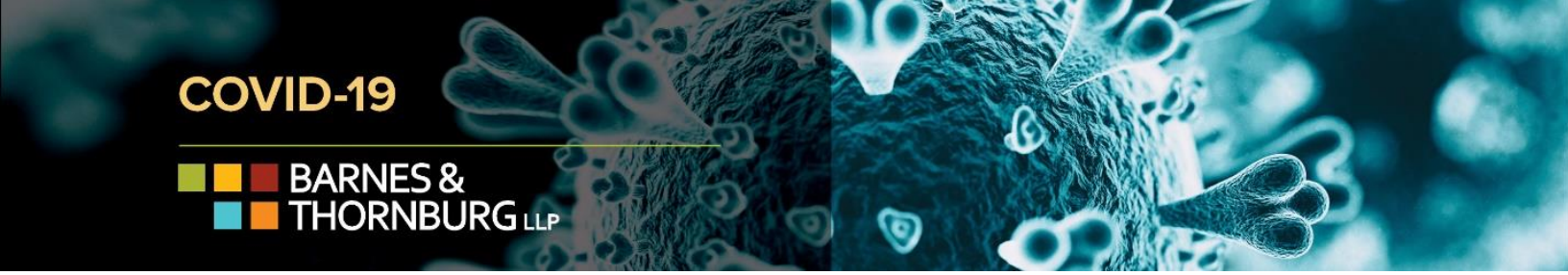
A: There are no prohibitions on ancillary service providers providing services to residents in long term care (LTC) facilities. However, with the increasing number of COVID-19 cases arising in these facilities, many LTC facilities have banned all outside visitors or have imposed significant restrictions. As such, it is best to check with each facility individually and to exercise caution when providing services in LTC facilities.

FRAUD, WASTE, AND ABUSE

Physician Compensation Issues

Q: How may/should hospitals contract with providers for direct patient care, screening, and treatment related to COVID-19?

A: When determining how to structure a compensation arrangement for frontline providers (e.g., emergency medicine physicians and nurses) during the COVID-19 pandemic, employers may use emergency medicine benchmark data across the board for all providers or may use each provider's specialty's benchmark data. In either case, it would also be reasonable to pay providers a premium for services provided during the COVID-19 pandemic, due to the extenuating circumstances the providers will face in treating and evaluating patients related to COVID-19.



Q: How can existing compensation arrangements, particularly productivity-based arrangements, be updated while the COVID-19 pandemic is ongoing?

A: Physicians may see an increase or decrease in typical productivity during the COVID-19 pandemic, depending on the physician's specialty, whether the physician performs elective procedures, and whether a physician may be redeployed to support COVID-19 efforts. Employers may offer a guaranteed compensation for the COVID-19 pandemic period, based on average productivity numbers in a given specialty. After the pandemic period ends, the employ can then evaluate a physician's productivity to determine whether the guaranteed compensation or the physician's actual productivity more accurately reflects a particular physician's services and contributions through the year.

For more information about structuring physician compensation arrangements during the COVID-19 pandemic, see the following BT Alert:

BT Alert: COVID-19 Pandemic Impact on Physician Financial Arrangements

Q: What is included in the blanket waiver of Stark Law provisions and when does it apply?

A: CMS issued a blanket waiver, retroactively effective as of March 1, 2020, of certain Stark Law provisions, only if the failure to comply is solely related to COVID-19, which includes securing services of physicians and other health care providers to provide medically necessary patient care services in response to the COVID-19 pandemic and addressing the medical practice and business interruption due to the COVID-19 pandemic. The blanket waiver provides the following - again, only if such is solely related to the COVID-19 pandemic:

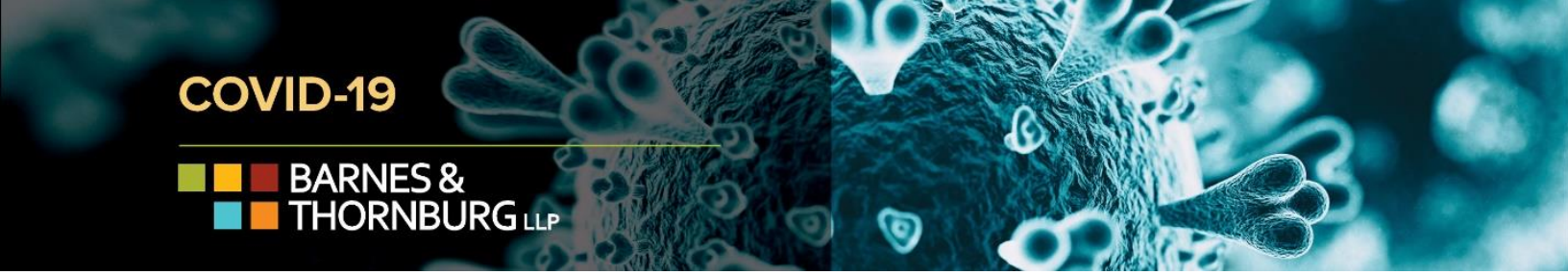
- Fair Market Value does not apply (though there could be Anti-Kickback Statute implications)
- Hospitals may loan physicians money that may be below the terms offered by financial institutions
- The current annual limits for medical staff incidental benefits and nonmonetary compensation do not apply
- Financial arrangements can begin without the requirement of the arrangement or contract being sign by the parties (though CMS has indicated that signatures should be obtained, when it is feasible)

If a provider or entity takes advantage of the waiver, it should do so consistently, meaning if a hospital waives an office rental payment for one independent physician practice during the COVID-19 pandemic, the hospital should waive rental payments for all independent physician practices. This will eliminate an argument that the hospital selectively waive rental payments.

Section 1135 Waivers

Q: What type of waivers are available under Section 1135?

A: Section 1135 waivers are issued by CMS when the president declares a natural disaster or public health emergency and waive certain Medicare, Medicaid, or CHIP program requirements in order to ensure that sufficient health care items and services are available to beneficiaries of those programs. Section 1135 waivers cover Medicare or Medicaid conditions of participation or payment, physician licensure requirements for providing emergency services out of state, and Stark Law physician self-referral sanctions. Waivers shelter healthcare providers from punishment related to the waiver and typically remain in effect until the end of the emergency period.



Q: What states have received Section 1135 waivers from CMS related to COVID-19?

A: For information regarding each of the COVID-19 Section 1135 waivers, please see:

Section 1135 Waiver Update

Medicare Beneficiary Cost-Sharing

Q: Are there changes to Medicare's prohibition on waiving or reducing beneficiary cost-sharing for services during the COVID-19 pandemic?

A: The Office of Inspector General (OIG) announced in a policy statement issued on March 17, 2020, that physicians and practitioners, as well as hospitals and other entities billing on behalf of the physician or practitioner, may waive or reduce Medicare beneficiary cost-sharing responsibilities for telehealth services. The OIG's policy statement applies only to services provided during the COVID-19 public health emergency declaration and is intended to apply to a broad category of "non face-to-face services," such as telehealth visits, virtual check-in services, e-visits, remote care management, and remote patient monitoring.

INSURANCE COVERAGE FOR COVID-19 LOSSES AND LIABILITIES

Q: Will losses and liabilities related to the COVID-19 pandemic be covered by a company's insurance policies?

A: Losses and liabilities related to the COVID-19 pandemic may be covered under a company's insurance policies, depending on the type of coverage and the claim. For example, business interruption insurance typically covers an insured's lost income resulting from a covered event, when the event results in an interruption or suspension of business. However, some of these policies cover only "contingent" business interruptions and apply only when a covered event damages a key business partner and impacts the policyholder's business. There may be other policies that would cover losses related to COVID-19, such as crisis management coverage, event cancellation coverage, and general liability insurance. Coverage under all of these policies varies, so it is best to consult your insurance broker or someone with expertise in this area.

For more information regarding COVID-19 insurance coverage and recovery issues, see the following BT Alert:

BT Alert: COVID-19 Insurance Coverage: Resource Guide

ADDITIONAL RESOURCES

For additional information and insights regarding COVID-19, see the COVID-19 Resources page on Barnes & Thornburg's website:

Barnes & Thornburg COVID-19 Resources