Detangling the Web:
How Health Care Providers can Mitigate the Economic Impact of the COVID-19 Outbreak

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Today's Agenda

- Key CARES Act Developments for Heath Care Providers
  - Today's announcement about HHS paying out $30 billion directly to providers
  - Medicare coverage and reimbursement developments
  - Regulatory flexibility for providers and suppliers
- Paycheck Protection Program, Economic Injury Disaster Loans & Other Provisions
- Medicaid Developments and State Actions
  - State Medicaid and CHIP waivers
  - State financial support & sources of private funding
- Public Health System: Challenges and Response
- Future Changes at Federal Level?

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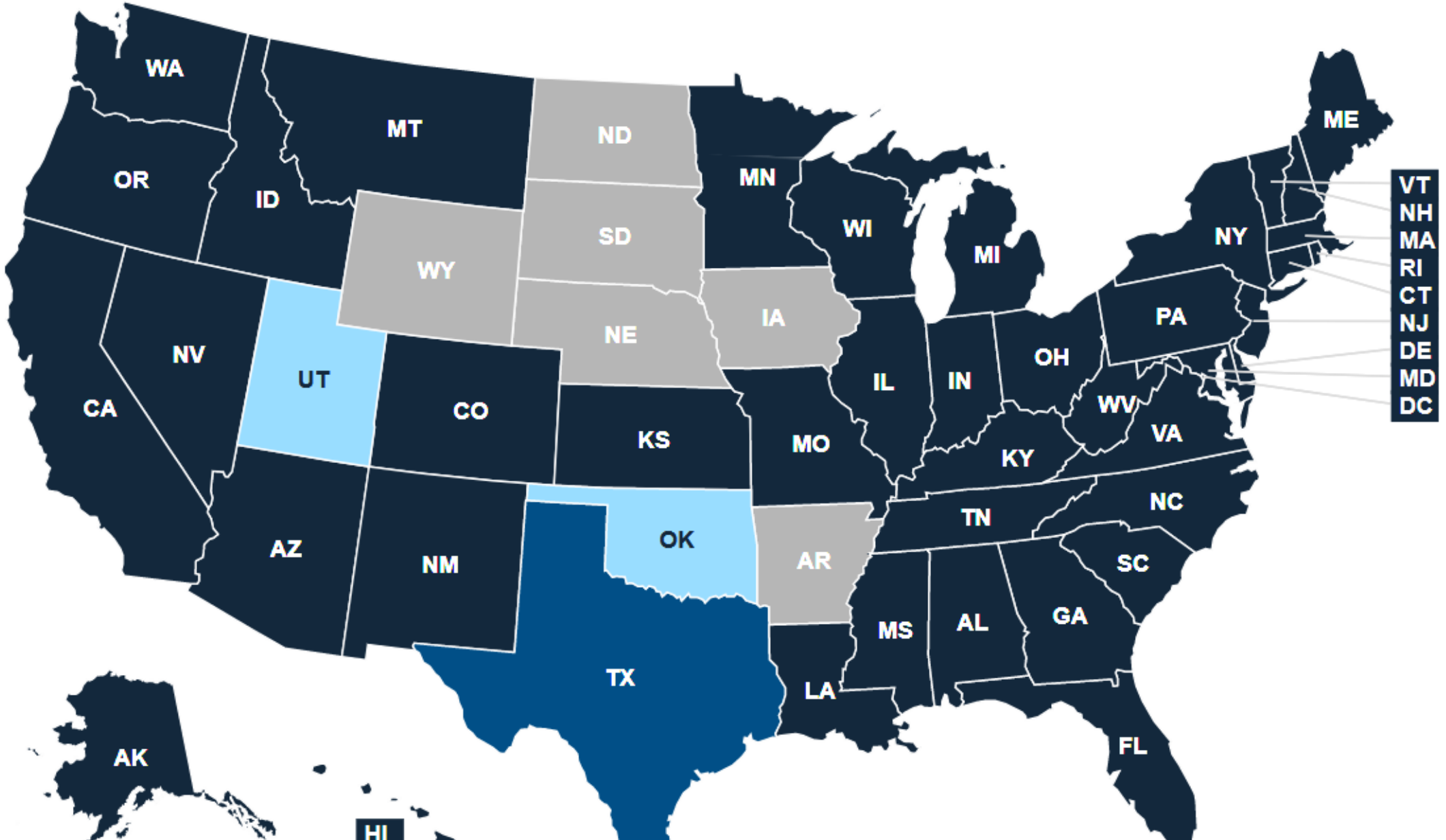
Background on Federal COVID Response

- Dec. 31, 2019, China reports cluster of cases of pneumonia in Wuhan, Hubei Province
- Jan. 4, 2020: WHO reports on social media about pneumonia cluster (no deaths) in Wuhan
- Jan. 12, China shares genetic sequence of COVID-19
- Jan. 13, first case of COVID outside China (Thailand)
- Jan. 22, China confirms human-to-human transmission
- HHS declares public health emergency Jan. 31
- Federal legislation:
  - Coronavirus Preparedness and Response Supplemental Appropriations Act (Mar. 3)
  - Families First Coronavirus Response Act (Mar. 17)
  - Coronavirus Aid, Relief and Economic Security Act (CARES) and Supplemental Appropriations Act (Mar. 27)

One Example of Where We Are Now: Stay at Home Orders



Resources: Keeping Track of All of This

- CMS:
  - Public Health Emergency (clearinghouse)
    - https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
  - Partner Toolkit (materials organized by provider / supplier category)
    - https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
  - Newsroom (sign up for updates)
    - https://www.cms.gov/newsroom
- Interim Final Rule on CARES Act (85 Fed. Reg. 19230, Apr. 6, 2020)
- Medicaid & CHIP
  - State Disaster Response Toolkit (state waivers)
    - https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html
- Kaiser Family Foundation
  - Status of Virus & State Policy Reponses
    - https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/

Public Health and Social Services Emergency Fund

- Established by Congress in 2005 in response to Hurricane Katrina
- $100 billion for providers for COVID related expenses (e.g., building or construction, leasing / properties, medical supplies/equipment, increased workforce training, emergency operation, retrofitting and surge capacity)
- Eligible providers include public entities, Medicare/Medicaid enrolled providers and suppliers and such other for-profit or non-profit entities as HHS specifies
- Minimal detail in statute is regarding process for obtaining funds:
  - Applicants required to justify financial need
  - HHS to review applications on rolling basis
  - Statutory payment methodology not clear (e.g., prospective v retrospective)
  - Recipients must maintain documentation to ensure compliance with program requirements

Public Health and Social Services Emergency Fund

- On Apr. 3, Administration announces intent to devote portion of $100 billion to aid providers in treating uninsured
- Kaiser Family Foundation analysis (Apr. 7) says using funds to pay hospitals for treating uninsured would consume 40% of the $100 billion
- Pushback from many in provider industry
- Apr. 7, Admin. Verma announced plan to distribute $30 billion (of $100 billion) to providers / suppliers based on Part A and B Medicare claims during 2019
  - Not provided on first-come, first-served basis
  - Direct deposit into bank accounts
  - “Essentially grants,” with “no strings attached” and providers “can spend any way they see fit”
  - Providers / suppliers who get majority of revenue from non-Medicare source (e.g., Medicaid, commercial, other govt. programs) will get priority for funds in next round of allocation

Public Health and Social Services Emergency Fund

- Apr.10, HHS announces process for paying $30 billion. Direct deposit starts today
- All providers that received FFS payments in 2019 are eligible. Payments sent to billing organization based on TIN
- As condition of receipt, providers must agree not to seek collection of out-of-pocket payments that are greater than what patient would have paid if care provided in network
- Amount allocated based on providers' share of total FFS reimbursement in 2019
  - Divide 2019 FFS by $484 billion, then multiply ratio by $30 billion
- United Health Group assisting in distribution
- Recipients must sign attestation within 30 days of receipt. Portal for attestation opens on Week of Apr. 13
- HHS illustrates how payments apply to different organizations

Reimbursement Changes in CARES Act

- General Changes:
  - Expansion of Medicare Accelerated Payment Program
    - Providers, suppliers apply with their Medicare Administrative Contractor (MAC)
    - Applications processed within 4-6 days
    - Extended period to repay MAC
    - Can request up to 100% of Medicare payments over 3 or 6 (hospitals) month period
    - As of Apr. 7, CMS had paid out more than $51 billion under Program
  - Delay in sequestration-based payment cuts (2% cut for Medicare fee-for-services)
  - Relaxation of National Coverage Determinations and Local Coverage Determinations for respiratory therapy devices and equipment
    - CARES Act Interim Final Rule made additional NCD/LCD changes to expand coverage
  - Pause in various reimbursement reviews:
    - Some MACs delaying targeted probe and educate reviews

Reimbursement Changes in CARES Act

- Changes for Specific Providers & Suppliers:
  - Hospitals
    - Positive DRG adjustment (20% add on for patients diagnosed with COVID)
    - $4 billion cut in Medicaid payment to DSH hospitals delayed until Dec. 1 2020
    - 2021 DSH reductions cut in half ($4 billion instead of $8 billion)
    - Long term care hospitals receive waiver of payment cuts if discharge percentage exceeds thresholds for care intensity
  - Clinical Labs
    - Delay in PAMA implementation and reporting. Translates to no payment reduction for time being.
  - Durable medical equipment suppliers
    - Pause in cuts implemented under competitive bidding program (higher rates stay in effect for duration of emergency)
  - Community health centers and rural health clinics
    - $1.32 billion in supplemental awards for COVID treatment
    - On Apr. 8, HRSA distributed more than $1.3 billion to 1,387 health centers

Nationwide Waivers → Regulatory Flexibility

- CMS issues nationwide “blanket” waivers on March 13, 2020, effective retroactively to Mar. 1:
  - Waiver of certain conditions of participation, certification requirements and program participation requirements
  - Waiver of individual state licensing requirements
  - Lifting of sanctions for violations of the EMTALA for the direction or relocation of an individual to another location to receive medical screening, or for the transfer of an individual who has not been stabilized, if the transfer is necessitated by COVID pandemic
  - Lifting of sanctions for violations of the Stark Law
  - Waiver of limitations on the ability to make direct payments to providers for services to Medicare Advantage enrollees
  - Lifting of sanctions for noncompliance with certain provisions of HIPAA
  - Modification of deadlines and performance of certain activities required for reimbursement

How CMS Sees Things

The Trump Administration issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. This unprecedented temporary relaxation in regulation will help the healthcare system deal with any patient surges by giving it tools and support to create non-traditional care sites and staff them quickly.

Telehealth

People with Medicare can now get telehealth services from their home, increasing their access to care.

Care by Phone

Patients can consult with a doctor, nurse practitioner, psychologist, and others and

Medicare will cover it.

Rapidly Expand Health Care Workforce

A physician who has to self-quarantine can be recruited to provide care virtually, or oversee care delivered by other clinicians through interactive video/ audio conferencing. And Medicare will pay for providers who are licensed in one state to provide care in a different state if they are needed. Health systems can provide care options that use population management strategies like triaging based on COVID status as well as clinical status, employing doctors, nurses and other staff to better manage high patient volumes. Clinicians who are not fully employed during the emergency can be repurposed to provide care in other areas.

Testing Patients Where They Are

If a person has a physician order for a lab test for COVID-19, they can go to a drive-up testing center. Or, a laboratory may be able to send someone to their home to collect a test sample.

Making the Most Use of Community Health Care Resources

Hospitals can transfer patients to different types of units and facilities to keep patients safe and free up beds.

COVID-only Care Centers

During the Public Health Emergency, hospitals and dialysis centers can set up COVID-only centers to help reduce transmission to others.

Expanding Hospital Capacity

Community resources like hotels, convention centers and surgery centers can be converted for hospital care.

Patients Over Paperwork

Administrative burdens have been reduced dramatically and permit frontline providers to triage patients and coordinate care despite high volume and extraordinary system stresses. By extending quality reporting deadlines and suspending medical necessity documentation, we are giving time back to doctors so they can focus on their patients. For example, provider documentation requirements for prior authorization are temporarily suspended. Additionally, we've made regulatory changes to provide temporary relief from many audit and quality reporting requirements so that providers, healthcare facilities, Medicare Advantage health plans, Part D prescription drug plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Regulatory Flexibility

- CMS has delayed reporting for variety of value-based / quality-based reporting requirements:
  - Most provider and supplier categories are subject to quality-based reporting obligations with meaningful payment cuts for failure to perform
  - Acute care hospitals, PPS-exempt hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehab facilities, long-term care hospitals, ambulatory surgery centers, renal dialysis facilities and physicians paid under Merit-based Incentive Payment System all receive a reprieve
  - Trend is to allow providers/suppliers not to report performance for patient encounters during COVID response period or to hold providers harmless based on triggered reductions
- Medicare enrollment process simplifications:
  - Waiver of numerous CMS-855 enrollment requirements (background checks, site visits, application fees, 7 day time frame for turning applications, postpones revalidation, grant temporary billing privileges via enrollment hotline)
  - Delay requirement to use multi-factor authentication for PECOS and NPPES

Regulatory Flexibility

- CMS has issued extensions on filing deadlines for cost reports (hospitals, SNF, HHA, hospice, LTCH, ESRD, IRF)
- CMS will exercise “enforcement discretion” for Open Payments Program (a/k/a Physician “Sunshine” Law) reports that are filed late
- Reconciling HIPAA and Part 2 (substance use disorder confidentiality)
  - Patient consent (given once) covers disclosure by Part 2 program, covered entity, business associate for treatment, payment, healthcare operations
  - Permits redisclosure of Part 2 information for treatment, payment, healthcare operations based on initial consent
  - HIPAA breach notification standards expanded to cover Part 2 records
  - Recipient of Part 2 information prohibited from discriminating against patient as pertains to treatment, employment, housing, access to court, workers comp or govt. benefits
  - Moves penalties for violating Part 2 from federal criminal law to HHS

Regulatory Flexibility

- All provider / supplier categories have received reduction in regulatory burden. Some from nationwide waivers; others from follow up CMS guidance.
- CMS has published provider / supplier specific “fact sheets” with description and citations of regulatory guidelines put on hold and overview of payment opportunities:
  - https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- Skilled Nursing Facilities
  - Non-SNF buildings temporarily certified for use in isolation; flexibilities for resident transfers; stay of 3-day hospitalization rule for SNF admission; more time to file minimum data sets
- Hospitals
  - Permitted to transfer patients outside of hospital walls (e.g., ASCs, inpatient rehab facilities, hotels and dormitories) while still receiving hospital-based reimbursement

Medicare Coverage Expansion

- Ambulatory surgery centers
  - Permitted to contract with hospitals to provide hospital services; permitted to temporarily enroll in Medicare as hospital and receive hospital-based payment
- Clinical Labs
  - Lab techs can travel to patients' homes to draw specimens; labs can perform testing in patients' homes and other community-based settings; pathologists can evaluate specimens remotely, expedited review of CLIA applications
- Dialysis centers
  - Special purpose centers that provide care only to patients with COVID
- Long Term Care
  - Waiver of requirement that patients of inpatient rehab facility receive at least 15 hours of therapy per week
- Ambulances
  - Permitted to transport patients to wider range of locations (i.e., physician offices, community mental health centers, FQHCs, ASCs, urgent care, dialysis)

Medicare Coverage Expansion

- Home Health Agencies
  - Permits physician assistants, nurse practitioners and clinical nurse specialists to certify need for home health services and establish home health plan of care
  - Changes definition of “homebound” for HHA benefit to include cases where “medically contraindicated” for patient to leave home
- Home and Community Based Service Providers
  - Acute care hospitals can provide home and community based services from hospital so long as services identified in care plan, not provided as substitute for hospital and designed to facilitate transition between hospital and HCBS setting

Medicare Coverage Expansion

- Coverage of COVID related services:
  - Part B will fully cover COVID-19 vaccines without any beneficiary cost-sharing
  - Parts C and D of Medicare are required to cover a 90-day supply of prescribed drugs without restrictions
  - Group health plans are required to reimburse providers at the parties' fully negotiated rate for diagnostic tests or the provider's publicly available cash price for the service. Group health plans are also required to cover (without cost-sharing) preventive services and immunizations for COVID-19
  - Providers required to publicly disclose their pricing for COVID-19 diagnostic tests

Medicare Coverage Expansion

- Telehealth
  - Telehealth Services During Certain Emergency Periods Act of 2020. Preceded CARES Act and made only limited adjustments to Medicare telehealth rules
  - CARES Act gave HHS authority to waive the section of the Social Security Act that governs Medicare's coverage rules for telehealth.
  - Other Changes from CARES
    - FQHCs and rural health clinics qualify as distant site providers.
    - Payment for telehealth from these settings comparable to Physician Fee Schedule Rates
    - Hospice physicians and nurse practitioners can conduct face to face encounters via telehealth
    - Home dialysis patients can receive assessments via telehealth (not face to face)
    - HHS directed to explore reimbursement for remote patient monitoring via telehealth
    - Enrollment of veterans in Veteran Directed Care Program can be done with telehealth visit

Telehealth Expansion (con't)

- Telehealth & Interim Final Rule
  - Most IFR changes temporary … but are they really?
  - Wholesale rewrite of telehealth under IFR:
    - Smart phones can meet Medicare "interactive telecommunications system" definition
    - Telehealth can be furnished to patients wherever located (including patient's home)
    - Physicians report the place of service code that would have been provided had care been rendered in person (along with -95 modifier). Reimbursement paid at same rates as if care delivered in person.
    - Significant expansion of services Medicare will cover if provided through telehealth (initial inpatient visits, initial nursing facility visits, group psychotherapy, ER visits).
      - **80 additional services** covered via telehealth during emergency.
    - Physicians can provide direct supervision virtually through real time audio/video
    - Confirms OIG position on waiver of cost sharing for telehealth, but expands to address broader array of remote services and applies to hospitals and other providers
    - Notes OCR waiver of HIPAA penalties for providers that use Face Time, Skype and other technologies

Other Developments from Interim Final Rule

- Changes for Academic Medicine
  - Changes to teaching physician and moonlighting regulations
    - Teaching physician physical presence during key / critical part of procedure through telehealth
    - All levels of outpatient E/M (not just low/mid-level) can be provided by resident with teaching physician supervising via telehealth (interpretation of diagnostic radiology and psychiatry services too)
    - Residents under quarantine (who can furnish services that do not require face-to-face visit) can bill for teaching physician services if resident is under direct supervision via telehealth
    - Moonlighting residents permitted to bill for services not related to their approved GME and performed on inpatients (previously, only outpatient or emergency could be billed)
  - Changes for Direct and Indirect Graduate Medical Education
    - Teaching hospitals can claim residents for DGME and IME if hospital pays residents salary / benefits for time resident is at home or in home of patient and performing duties within scope of approved residency program

Other Developments from Interim Final Rule

- National Coverage Determinations & Local Coverage Determinations
  - Eliminates any NCD or LCD requirement for face-to-face visit or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services
    - Not applicable to face-to-face requirements in Medicare Statute (e.g., power mobility devices)
  - Some NCD/LCD require specific specialty or practitioner category to furnish service. Rule permits chief medical officer or equivalent to authorize any physician / practitioner to meet those requirements
  - Certain NCD/LCD require physician / certain specialties to supervise specific practitioners. IFR gives CMO discretion to use alternative provider.
- Expansion of hospital "under arrangement" options
  - Previously, certain services cannot be obtained under arrangement. IFR changes to allow hospitals to furnish services to inpatients outside of hospital walls.
- Accountable care organizations
  - Relaxes MSSP policy on "extreme and uncontrollable circumstances" so that ACOs will not be penalized for suboptimal quality reporting

Flexibility Under Stark Law & Anti-kickback Statute

- CMS releases Stark Law waivers on Mar. 30, 2020, effective Mar. 1
- Waivers protect remuneration between an entity and physician and referrals from the physician to the entity so long as the remuneration and referrals are “solely related to COVID-19 purposes” COVID-19 Purposes include:
  - Addressing medical practice or business interruption due to the outbreak so as to maintain the availability of medical care and related services for patients and the community
  - Securing services of physicians and other practitioners to provide patient care services
  - Ensuring the ability and expanding the capacity of providers to address patient and community needs due to the outbreak
  - Shifting diagnosis and care of patients to alternative settings
  - Diagnosis or treatment of COVID

Flexibility Under Stark Law & Anti-kickback Statute

- Waives all sanctions related to the exchange of specific types of remuneration. Examples include:
  - Payments that are above or below FMV of services provided, equipment/space leased
  - Loans between DHS entities and physicians that are on favorable terms, including below market interest rates
  - Referrals by physician owners to group practices they own that fail to meet certain elements of relevant Stark Law exceptions
  - Payments that exceed limits established under nonmonetary compensation or medical staff incidental benefits exceptions
  - Expansion of rural provider exception
  - Arrangements between entities and physicians that fail to meet the “writing” and “signature” requirements of various exceptions
- 18 separate Stark Law waivers
- Can also submit requests for individual waivers (via email)

Flexibility Under Stark Law & Anti-kickback Statute

- On Apr. 3, 2020 OIG issued policy statement: OIG will not impose AKS sanctions for remuneration covered under majority of the Stark Law Waivers. OIG Policy effective after Apr. 3.
- OIG positon applies to 11 of the 18 types of remuneration waived under Stark Law Waivers. Waivers 12-17 not encompassed under OIG guidance, but likely due to technical differences between Stark Law and Anti-kickback Statute and not policy judgement.
- Stark Law waivers and OIG policy terminate at end of Public Health Emergency

Flexibility Under Stark Law & Anti-kickback Statute

- Other OIG guidance:
  - Mar. 17: no administrative sanctions for waiving telehealth cost sharing obligations
  - Mar. 30, “Message from leadership on minimizing burdens on providers”: For any conduct during this emergency that may be subject to OIG administrative enforcement, OIG will carefully consider the context and intent of the parties when assessing whether to proceed with any enforcement action.
  - Apr. 3: FAQ addressing providers furnishing services for free / reduced costs to assist long-term care providers with staff shortages. OIG said, low risk of fraud and abuse so long as services offered are:
    - Necessary to meet patient care needs as a result of staffing shortages directly connected to the outbreak
    - provided for free or at a reduced cost only when necessary as a result of outbreak
    - limited to the period subject to the emergency declaration; and
    - Not contingent on referrals for any items or services that may be reimbursable in whole or in part by FHCPs, either during or after declaration

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Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") SBA loan provisions are main focus today

- **Economic Injury Disaster Loans ("EIDL")**
  - $10B direct appropriation
  - Generally for <500 employee businesses
  - Loans up to $2 million
- **Paycheck Protection Program ("PPP")**
  - $349B direct appropriation
  - Generally for <500 employee businesses (affiliation and franchise waivers)
  - Loan forgiveness potential = *lesser of* 2.5 x monthly payroll or $10 million
  - For full forgiveness, must maintain or re-employ certain wage levels and employee numbers, and certify 75/25 for wages vs. rent/utilities/interest (over 8 weeks up to June 30)

CARES Act – other provisions

- **Individuals/Employees**
  - Expanded unemployment eligibility; additional $600/week thru end of July
  - Cash infusion: $2,400 (married)/$500 per child, phased out $150,000 - $198,000 (married)
  - Qualified retirement account 10% early withdraw penalty waived
- **Tax provisions to help businesses**
  - Employee Payroll Retention Tax Credit (for employers who do not use PPP)
  - Employer deferment of 6.2% Social Security tax
  - Expansion on company's use of Net Operating Loss and Taxable Income limits
- **Other SBA**
  - Small businesses w/ existing SBA loans may receive up to 6 mos. forgiveness of current loans (P&I)
  - Forgiveness also available for borrowers who take certain new SBA loans in next 6 months
- **Healthcare**
  - $100B for hospitals and institutional providers (incl. nonprofits) for unreimbursed "health care related expenses or lost revenues that are attributable to coronavirus"

CARES Act – other provisions (con’td.)

- **Agriculture producers ($9.5B)**
- **Economic Stabilization for Severely Distressed Sectors - Federal Reserve ($500B)**
  - Airlines ($29B)
  - Loans for large employers w/ 500-10,000 employees ($471B)

Paycheck Protection Program

- New 7(a) SBA Business Loan Program created under the CARES Act.
- Program end June 30, 2020.
- PPP Loans will be made through SBA approved third party lenders.

Eligible Borrowers

In addition to SBA “small business concerns”:

- a business concern if employs not more than 500 employees; (unless industry has a higher size standard under SBA rules),
- nonprofit organization, veterans’ organization, or Tribal business if employs not more than 500 employees;
- In operation on February 15, 2020; and
- Had W-2 employees or 1099-MISC independent contractors.

Note: Individuals operating as sole proprietorship or independent contractor/eligible self-employed individuals are eligible

Special Eligibility Rules (1 of 2)

Accommodation and Food Service Businesses

Accommodation and food services businesses (NAICS Section 72) with more than 1 physical location are eligible, if employs 500 or fewer employees per location.

Special Eligibility Rule (2 of 2)

Affiliation Rules

Affiliation Rule: Generally, entity "affiliates" are combined for purposes of determining number of employees. See SBA 121.301

Rule Waived: For (1) accommodation and food services businesses with 500 or fewer employees; (2) franchise businesses that are approved on the SBA's Franchise Directory; and (3) any business that receives financial assistance from a company licensed under section 301 of the Small Business Investment Act.

Note: "Affiliation" exists when 1 business can control another or when a 3rd party can control both. Control not just majority ownership – can arise from management, or other relationships or interactions between the parties.

Affirmative or Negative Control. Negative: minority owner has the ability to prevent a quorum or otherwise block action by board/majority owners. However, control can be waived by agreement (at least for <50% owners).

Loan Limits

Overall loan cap is $10 million.

Up to the cap, the maximum loan amount is:

1. 2.5 times average monthly “payroll costs” incurred in the 1-year period before the loan date or average “payroll costs” for calendar year 2019.

Plus

2. Balance of any EID Loan being refinanced.

Payroll Costs

- Payroll costs include salary/wages/tips, sick/family leave/PTO, severance payments, group health benefits (including insurance premiums), retirement benefits, and state or local taxes on employee compensation.
- For any employee who is paid more than $100,000 salary, only the amount up to $100,000 (prorated) is calculated.
- Compensation of employees with non-U.S. principal residences are excluded.
- Excludes special 2 week payments under the Families First Coronavirus Response Act.

Use of Loan Funds (“Keeping the Lights On”)

(1) payroll costs;

(2) continuation of group health care benefits during periods of paid sick, medical, or family leave, or insurance premiums;

(3) salaries or commissions or similar compensation;

(4) interest on mortgage obligations;

(5) rent;

(6) utilities; and

(7) interest on other outstanding debts.

In addition, funds can be used for other purposes allowed under 7(a) Business Loan Program. This broadens potential uses, but note that the applicant must acknowledge “that funds will be used to retain workers and maintain payroll or make mortgage payments, lease payments, and utility payments”.

General Loan Terms

Interest Rate: The interest rate is not to exceed 4%.

Personal Guarantees: No personal guarantees.

Collateral: No collateral.

Payment Terms: If a balance remains after loan forgiveness, the maximum maturity of 10 after the forgiveness request.

Payment Deferral: PPP Loan payments can be deferred from 6 months to 1 year.

Borrower Requirements: “No cheating” good-faith certification.

Loan Forgiveness

- Amount spent by the borrower on forgivable costs during the 8-week period after loan made.
- Forgivable costs: (1) payroll costs (*including additional wages paid to tipped employees*); (2) interest on mortgage obligation; (3) rent; and (4) utilities payments.
- Must maintain same average FTEs during 8 weeks as existed on average between February 15, 2019 and June 30, 2019 and have maintained at least 75% of compensation for each applicable FTE or 100% FTEs and compensation on June 30, 2020.

Department of Treasury
PPP Information Sheet and Application

Department of Treasury release a Borrower Information Sheet and sample PPP Loan application on March 31, 2020.

Forgiveness Rule. Language indicates that forgiveness for non-payroll costs will be limited to 25% of the forgiven amount. Not provided for in the CARES Act.

Interest Rate: 1.0%

Maturity: 2 years from loan date. This is not in conflict with the CARES Act, however, this is a shorter time frame that anticipated.

Availability. Now as approximately 400,000 loans have already been approved with anticipation of more funds coming from the government.

Economic Injury Disaster Loans

- Made under existing SBA Disaster Assistance Program.
- Your state must be declared a disaster to the SBA.
- Must satisfy number of employees and maximum cash receipts test of SBA. See SBA Size Standards.
- Expanded through December 31, 2020.
- Made directly from SBA (no third party lenders).
- SBA has streamlined online process for applying - https://covid19relief.sba.gov/#/

Eligibility

- Been in operation on January 31, 2020.
- In addition to current eligible businesses, businesses, cooperatives, ESOPs and tribal concerns with 500 or fewer employees;
- Private non-private organizations;
- Any individual who operates as a sole proprietorship, with or without employees, or as an independent contractor.

General Loan Terms

Interest Rate: 3.75% for businesses, 2.75% for non-profits

Payment Term: Long-term, up to 30 years.

Payment Deferral: Can be deferred up to 1 year.

Personal Guarantees: Required for loans of more than $200,000.

Collateral: Generally required, *if available*. May not apply to loans of $200,000 or less. SBA stated it will waive collateral requirements, but not required by Act.

Creditworthiness: Can be approved based on credit scores or "alternative appropriate methods to determine an applicant's ability to repay."

Use of Funds (Working Capital Loan)

EID Loans are fundamentally working capital loans.

CAN be used to pay (1) fixed debts; (2) payroll, (3) accounts payable and (4) other bills that can’t be paid because of the disaster’s impact.

CAN be used for other items like inventory if not an expansion of business or outside ordinary course.

CANNOT be used for refinancing, expansion, growth, or infrastructure improvements.

Emergency Advance

- Emergency advances are available.
- Up to $10,000.
- Does not have to be repaid, **even if application is denied**.
- Awarded within 3 days of application.
- “Can I apply just to get the emergency advance”?

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State Medicaid and Children's Health Insurance Program (CHIP) Waivers

- On March 13, 2020, President Trump declared the COVID-19 outbreak in the United States constituted a national emergency, beginning on March 1, 2020.
- Following the President's proclamation, the Secretary of the United States Department of Health and Human Services (HHS) invoked his authority to waive or modify certain Medicare, Medicaid, and CHIP requirements to meet the needs of Medicaid enrollees in affected areas as a result of the consequences of the COVID-19 pandemic.
- States have been able to ask CMS to approve waivers for Medicaid provisions, which have been granted to numerous states.
- Waivers are retroactive to March 1, 2020.

States receiving Medicaid Waivers

- Following the Secretary's action, waivers have been issued for the following states and territories:
  - Maine, U.S. Virgin Islands, Nevada (April 7, 2020)
  - Michigan (April 6, 2020)
  - District of Columbia (April 3, 2020)
  - Nebraska, Alaska, Arkansas (April 2, 2020)
  - Georgia April 1, 2020)
  - Tennessee, South Carolina (March 31, 2020)
  - Texas, Montana, Vermont, West Virginia (March 30, 2020)
  - Wyoming, Minnesota, Delaware, Pennsylvania, Connecticut (March 27, 2020)
  - Maryland, Colorado, Hawaii, Idaho, Massachusetts, New York (March 26, 2020)
  - Oregon, Missouri, Kentucky, Kansas, Rhode Island, Indiana, Iowa (March 25, 2020)

More States Receiving Medicaid Waivers

- Oklahoma, South Dakota, North Dakota (March 24, 2020)
- Alabama, California, New Hampshire, New Mexico, New Jersey, Arizona, Virginia, North Carolina, Mississippi, Louisiana, Illinois (March 23, 2020)
- Washington (March 19, 2020)
- Florida (March 16, 2020)

Waiver Provisions

- **PROVIDER ENROLLMENT – Relaxed Enrollment Requirements**
  - Certain provider screening requirements - (AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, VT, WA, WV, WY)
  - Postpone deadlines for revalidating providers - (AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, VT, WA, WV, WY)
  - Allow out-of-state providers with equivalent licensing in another state – (AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, VT, WA, WV, WY)
  - Allow out-f-state providers to provide care to emergency state's Medicaid enrollee – (AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, VT, WA, WV, WY)
  - Allow provision of services in alternate settings, including unlicensed facilities – (AK, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NV, NY, OK, OR, PA, SC, SD, TN, VT, WA, WV, WY)

Waiver Provisions

- **PRIOR AUTHORIZATIONS**
  - Suspend Requirement for Fee-for-Service Care - (AK, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OK, OR, PA, RI, VA, VT, WA, WV, WY)
  - Require providers to extend pre-existing prior authorizations for Fee-for-Service Care - (AK, AZ, CA, CO, CT, DC, DE, FL, GA, ID, IL, IN, KS, MA, MD, ME, MI, MO, MS, MT, ND, NH, NJ, NM, NV, NY, OR, PA, RI, SC, TX, VA, VT, WA, WV)
- **Appeals**
  - Modification of Fair Hearing Timeline -Give enrollees >120 days for (MC) appeals or >90 days (FFS appeals) to request state fair hearing – (AK, AR, CA, CO, CT, DE, FL, GA, HI, IL< IN, KS, KY, LA, MA, MD, ME, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TX, VA, VT, WA, WV, WY)
  - Allow managed care enrollees to bypass health plan appeal and go directly to fair hearing - (AR, CA, CT, DE, FL, GA, HI, IL, IN, KS, KY, LA, MA, MD, MN, MO, MS, NC, ND, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SD, VA, VT, WA, WV)

Waiver Provisions

- **Long Term Services & Supports**
  - Suspend Pre-Admission Screening and Annual Resident Review (PASRR) Level 1 and Level II Assessments for 30 days - (AK, AL, AR, AZ, CO, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, SC, SD, TN, TX, VT, WA, WV, WY)
  - Extend minimum data set (MDS) authorizations for Nursing Facilities and Skilled Nursing Facilities
- **Reporting & Oversight**
  - Modify deadlines for OASIS and MDS assessment & transmission
  - Suspend aide supervision requirement by RN for Home Health agencies
  - Suspend supervision of hospice aides by RN

Waiver Provisions

- **State Plan Amendment Flexibilities**
  - Modified deadline for submitting COVID-19 related State Medicaid Plans (SPAs) effective for first calendar quarter of 2020 – (AR, CO, CT, DC, HI, MA, MD, ME, MI, MN, MO, NE, SC, WV)
  - Waive public notice for submission of emergency related SPAs and/or Section 1115 waivers - (AR, CO, CT, DC, HI, MA, MD, ME, MI, MN, MO, NE, NV, SC, TX, WA, WV)
  - Modify tribal consultation timeframe for submission of emergency related SPAs and/or section 1115 waivers

Source for approved Waiver applications – www.Medicaid.gov/state -resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54091

Emergency Preparedness and Response

- Home health and Community-Based Services (HCBS) Waivers
  - May include:
    - Establishing hotlines;
    - Increasing number of individuals served under a waiver, temporarily increase individual eligibility cost limits;
    - Create an emergency person-centered service plan;
    - Expand provider qualification to increase the pool of providers who can render services;
    - Expand or institute opportunity for self-direction;
    - Modify service, scope, or coverage requirements;
    - Exceed service limitations;
    - Add services to the waiver;
    - Provide services in out of state settings, and/or
    - Allow payment for services rendered by family caregivers or legally responsible individuals.

CHIP State Plan Amendments

- In March 2020, CMS created a template to assist states to respond to the COVID-19 national emergency and allow states to submit CHIP State Plan Amendments to allow temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in disaster areas.
  - Template streamlined the process for states to apply.
  - Approved CHIP SPA approval effective 03/01/2020
    - Main – updated to provide temporary adjustments to the state's premium lock out period in response to disaster events; and provided temporary adjustments to the cost-sharing requirements, application and redetermination policies, verification requirements, and tribal consultation process.

State Plan Amendments

- Amendments to respond to the COVID-19 national emergency include assistance for a variety of services related to:
  - Disaster Relief
  - Benefits
  - Financing & Reimbursement
  - Federal Financial Participation
  - Premiums
  - Prescription Drugs
  - Eligibility
  - Current State Plan
  - Cost Sharing
  - Outreach & Enrollment
  - Program Administration

Families First Coronavirus Response Act (FFCRA)

- Enacted on March 18, 2020 to provide temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) beginning January 1, 2020 and through the last day of the calendar quarter when the COVID-19 public health emergency terminates.
  - Requires states to cover testing services and treatments for COVID-19
    - Including vaccines, specialized equipment and therapies;
    - States may not impose deductibles, copayments, coinsurance or other cost sharing for COVID-19 testing services and treatments;
    - All Medicaid beneficiaries must receive continued coverage until the emergency ends;
      - States cannot terminate coverage for beneficiaries enrolled as of March 18, 2020;
      - But states may terminate individuals who request to voluntarily terminate coverage or if a beneficiary is no longer a resident of the state.

Other Financial Support Options for Health Care Providers

- In addition to the CARES Act financial resources, funding and other financial relief is also available through many new and existing programs to assist healthcare providers address the COVID-19 national emergency.
- States and other organizations also are providing special programs to help health care providers with financial support.

Centers for Disease Control (CDC)

- On March 6, 2020, the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123).
  - The act provides funding to prevent, prepare for, and respond to COVID-19.
  - Included no less than $950 million for grants and cooperative agreements
  - CDC Grant Management and COVID-19 Funding
    - On March 16, CDC awarded $570 million to state, tribal, local, and territorial health departments for initial response activities
    - Tribal and partner funding – Cherokee Nation was funded under this award – Funding for other tribes and partner organizations will be awarded by the Center for State, Tribal, Local, and Territorial Support (CSTLTS)
    - Supporting other federal entities (e.g., IHS hospitals/clinics) is not allowed – Providing federal response funds to other federal entities would amount to supplementing their appropriations, which is not allowed

Coronavirus Preparedness and Response Supplemental Appropriations Act 2020

- **National Special Pathogen System**
- HHS will provide $100 million to aid US healthcare systems prepare for surge in COVID-19 patients
- Support to benefit the National Special Pathogen System
- Funds will be available through 62 HHS Hospital Preparedness Program (HPP) cooperative agreement recipients and state or jurisdiction special pathogen treatment centers, as well as hospital associations
  - To support healthcare coalitions plan, train, and respond to disasters
  - To support urgent preparedness and response needs of local hospitals and other healthcare facilities
- Resource: https://www.hhs.gov/about/news/2020/03/24/hhs-provides-100-million-to-help-us-healthcare-systems-prepare-for-covid-19-patients.html

National Institute of Health (NIH)

- NIH offers funding for many types of grants, contracts, and programs to help repay loans for researchers.
- Due to the COVID-19 health care emergency, and concerns for health and safety of people involved in NIH research, late applications will be accepted through May for deadlines between March 9 and May 1, 2020.
- National Institutes of Health funding to support research to expand on prior research plans, including developing an improved understanding of the prevalence of COVID-19, its transmission and the natural history of infection, and novel approaches to diagnosing the disease and past infection, and developing countermeasures for the prevention and treatment of its various stages.

Health Resources and Services Administration (HRSA)

- HRSA works across diverse programs — serving everyone from infants to the elderly — to assure that people in the U.S. have access to a broad range of essential personal and public health services.
- With more than 3,000 grantees, we support hands-on health care, clinician training, research and more HRSA works to**:**
  - improve health care access and quality;
  - promote best practices; and
  - eliminate health disparities.
- To accomplish its mission, HRSA provides grants and cooperative agreements.
  - Recent supplemental funding has been awarded to various health clinics and health centers for coronavirus preparedness and response
- Application information for grants is available :https://www.hrsa.gov/grants/apply-for-a-grant

Federal Emergency Management Agency (FEMA)

- Under the direction of the White House Coronavirus Task Force, FEMA, HHS and its federal partners are working with state, local, tribal and territorial governments to execute a Whole-of-America response to fight the COVID-19 pandemic and protect the public.
- The national emergency declaration authorized Public Assistance Category B reimbursement for emergency protective measures.
- Recipients for reimbursement include states, tribes, or territories that receive and administer Public Assistance awards. Applicants are state, local, tribal and territorial governments, or eligible private nonprofits, submitting a request for assistance under a recipient's federal award.

Other Potential Federal Agency Sources of Funding

- Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding for community behavioral health services, suicide prevention programs, and other substance abuse or mental health programs.
- CMS funds to provide assistance to nursing homes with infection control and to prevent the spread of COVID-19 in these facilities.

Other Funding Sources of Interest to Health Care Providers

EXAMPLES OF STATE SOURCES OF FUNDING

- Kansas Hospital Association has applied for an ASPR Grant (Assistant Secretary for Preparedness and Response)
  - Awards will be made to state associations by mid-April with payments to hospitals by early May
  - Hospitals will be required to provide documentation and reports to receive funding
- Minnesota has introduced several programs including but not limited to its Small Business loan Guarantee Program and the Small Business Emergency Loan Program for Minnesota businesses.
- Colorado COVID Relief Fund's purpose is to raise and coordinate allocation of funds based on prevention, impact and recovery needs of community-based organizations in Colorado. This Fund is organized to ensure that the most acute community needs across the state are being addressed and that community voice is reflected in all funding decisions made over time. https://covrn.com/covid-relief-fund/

Foundations and Corporate Funds Announce Covid-19 Grants – a few examples of the many grants available

- **Wells Fargo Foundation** $175 million to make donations toward food, shelter, small business, and housing stability, as well as to provide help to public-health organizations during the coronavirus pandemic.
- **Sony** $100 million to create the Sony Global Relief Fund for Covid-19, which will support people and organizations around the world who are affected by the coronavirus.
- **Visa Foundation** $70 million pledge to support charities and nongovernmental organizations following the spread of Covid-19. Of the pledge, $10 million is designated for immediate emergency relief through frontline charitable organizations working in public health and food relief worldwide.
- **Mother Cabrini Health Foundation** $50 million pledge to support nonprofit organizations across New York State to address health-related needs resulting from Covid-19.

More Examples of Foundation and Corporate Fund Grants

- **UnitedHealth Group** $50 million to fight the Covid-19 pandemic and support frontline health-care workers, states with the greatest spread of infection, seniors, and people experiencing food insecurity or homelessness.
- **Robert Wood Johnson Foundation** $50 million to groups that provide food, housing, and cash to people hardest hit by the coronavirus epidemic.
- **Lilly Endowment** $48.5 million to help nonprofit groups, particularly those in Indiana, respond to the Covid-19 crisis.
- **PepsiCo and the PepsiCo Foundation** $45 million commitment to help people and communities worldwide contend with the coronavirus pandemic.
- **AbbVie** $35 million to International Medical Corps, Direct Relief, Feeding America, and other nonprofit partners to support their Covid-19 relief efforts.

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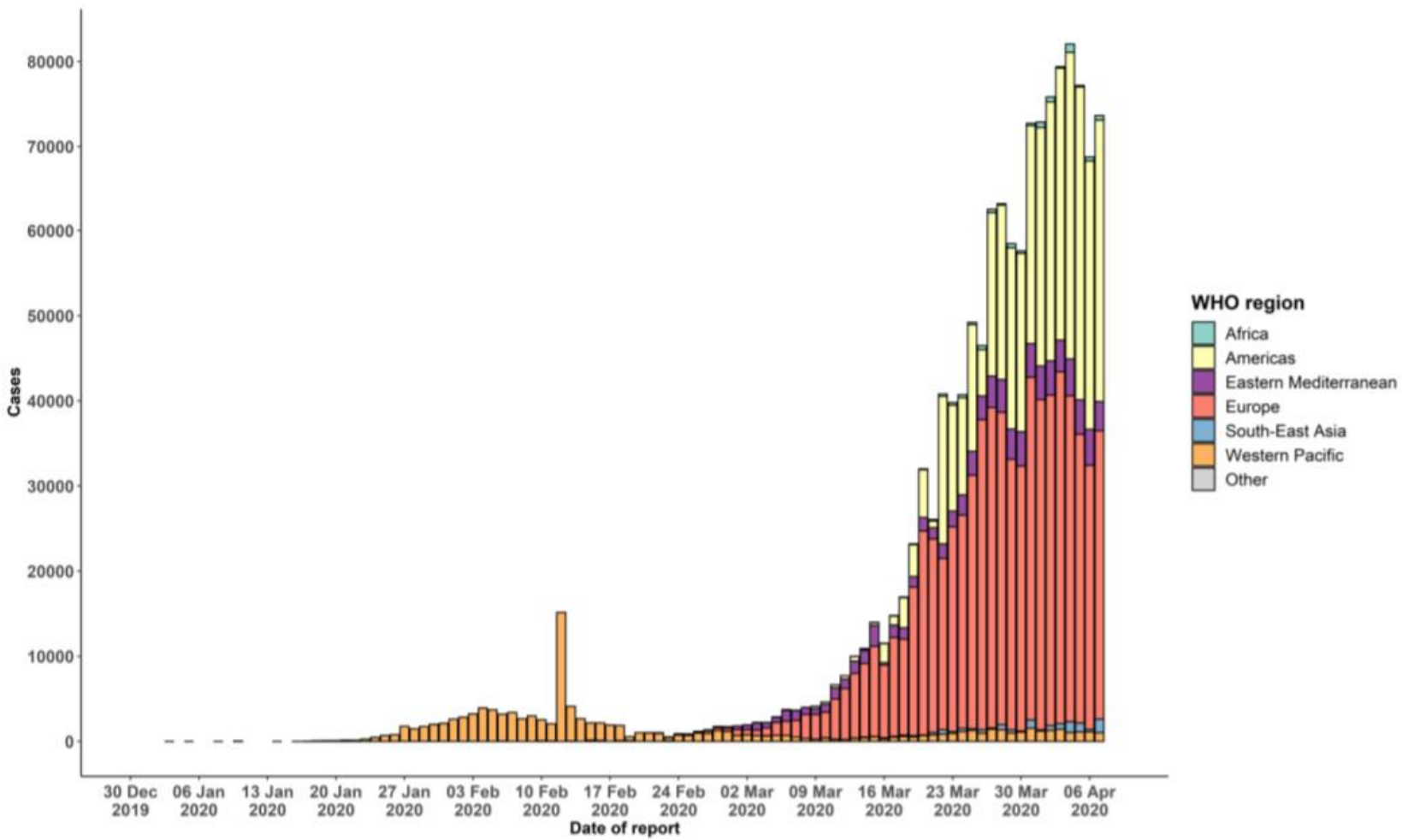
Public Health System's Response—Global

- Covid-19 is a global humanitarian crisis
  - Global efforts at this time are focused concurrently on lessening the spread and impact of the virus
- World Health Organization (WHO)
  - Primary role is to direct international health within the United Nations' system and to lead partners in global health responses
- Coordination with other global partners, such as the Global Outbreak Alert and Response Network (GOARN) UNICEF

Figure 1. Epidemic curve of confirmed COVID-19, by date of report and WHO region through 8 April 2020



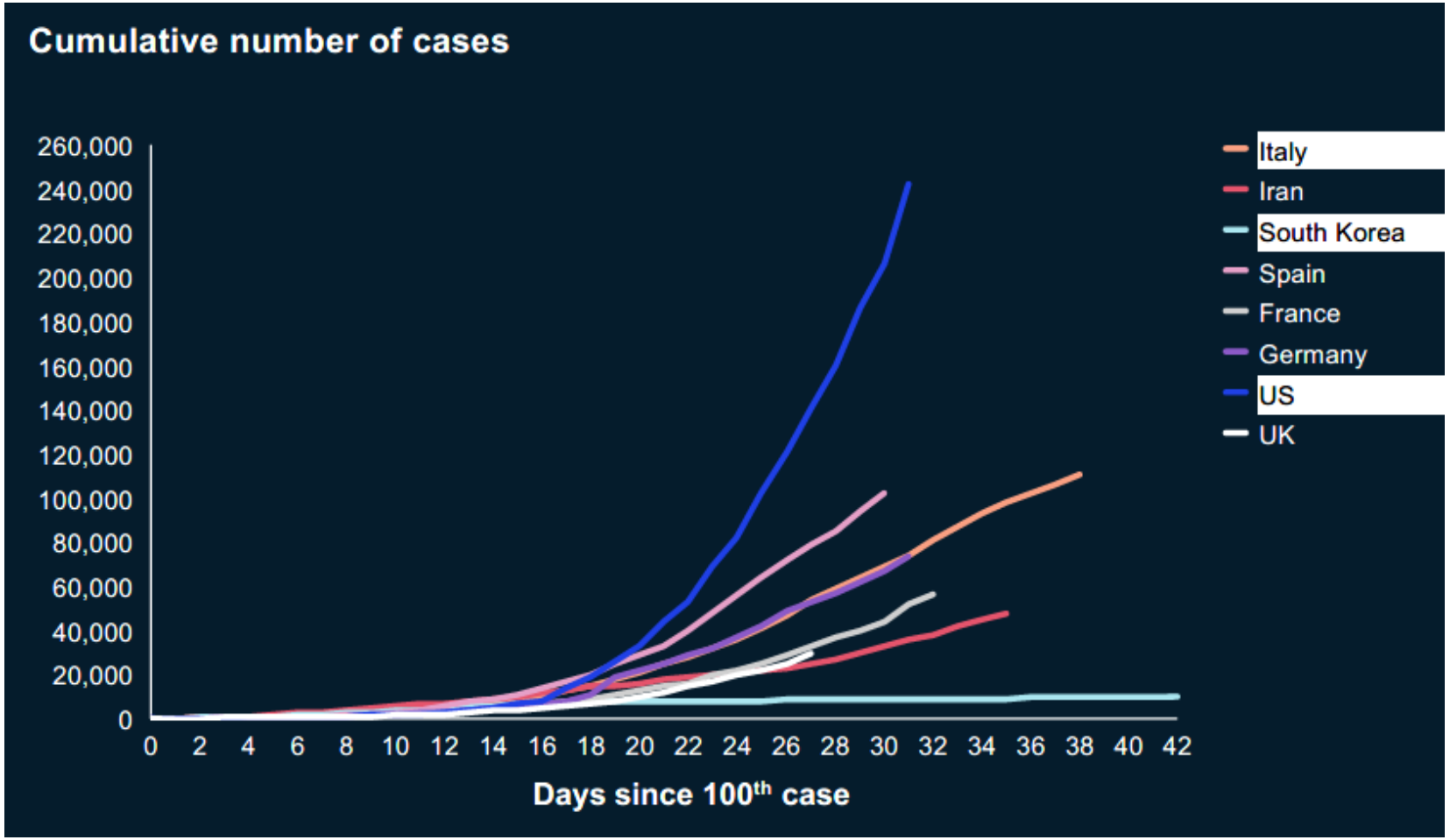
Source: WHO Situation Report, April 8 2020

Public Health System's Response—Global

- WHO objectives for COVID-19:
  - Interrupt human-to-human transmission
    - Including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread;
  - Identify, isolate and care for patients early, including providing optimized care for infected patients;
  - Identify and reduce transmission from the animal source;
  - Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
  - Communicate critical risk and event information to all communities and counter misinformation;
  - Minimize social and economic impact through multisectoral partnerships.
- Objectives achieved through a combination of public health measures:
  - Rapid identification and diagnosis
  - Management of cases
  - Identification and follow up of contacts
  - Infection prevention and control in health care settings
  - Implementation of health measures for travelers
  - Awareness-raising in the population and risk communication

Public Health System's Response—Global

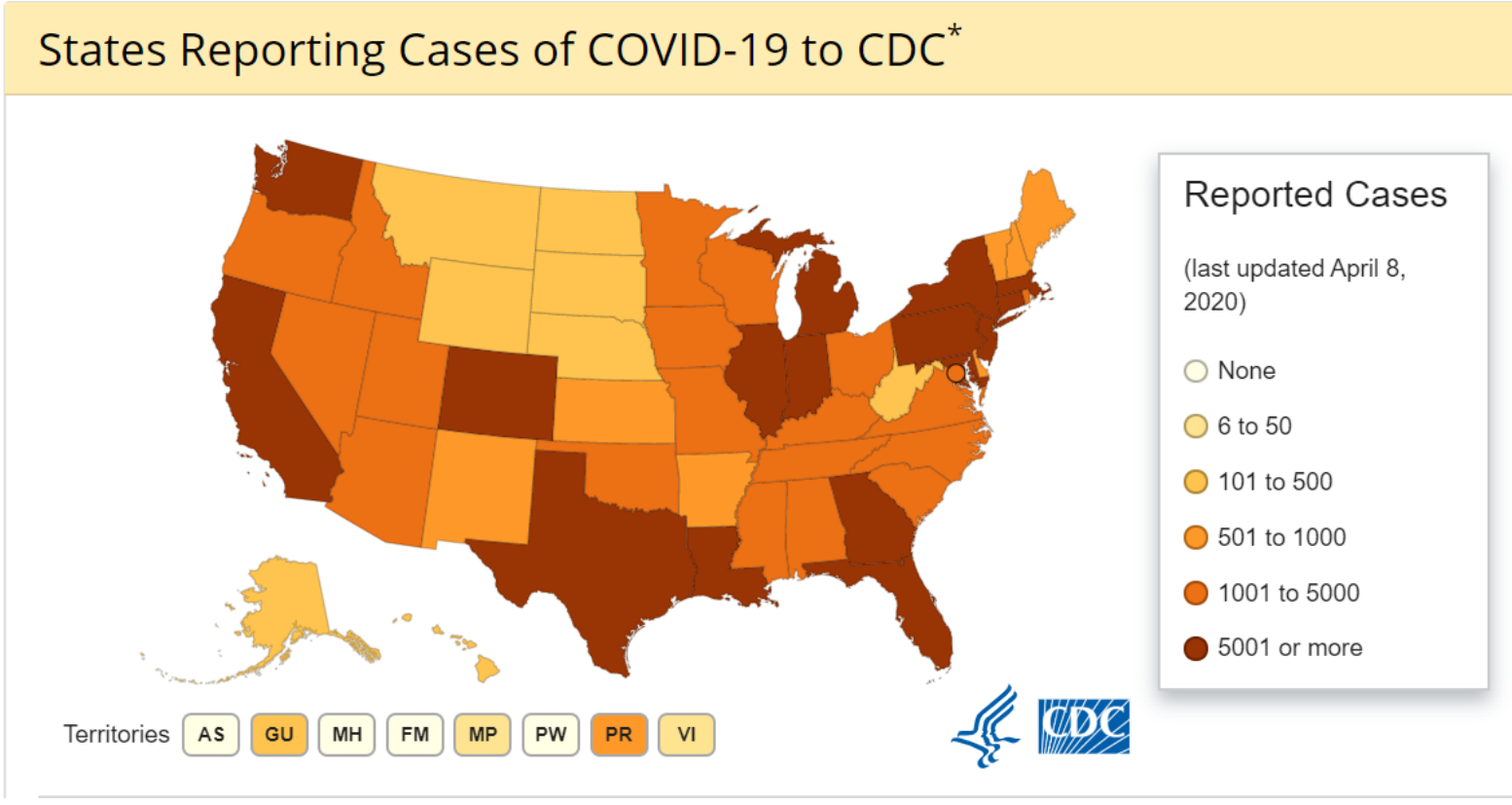
On the global scale, countries begin with similar trajectories but then diverge based on the public health measures that are implemented



Source: McKinsey & Company COVID-19 Briefing Materials; John Hopkins University CSSE; WHO Situation Reports.

Public Health System's Response—United States

- U.S. now has the highest number of confirmed cases in the world
- The U.S. public health system's response has differed at federal, state, and local levels
  - The federal government is working with state, local, tribal, and territorial partners, as well as public health partners, to respond to the pandemic
  - The Centers for Disease Control and Prevention (CDC) is the leading national public health institute of the United States
    - Highlights of CDC response include:
      - Jan. 7 2020: Established COVID-19 Incident Management System
      - Issued travel warnings and guidance (including a Level 3 Travel Health Notice for cruise ship travel)
      - Issued clinical guidance (e.g., patient management, infection prevention and control, etc.)
      - Deployed multidisciplinary teams to support state health departments in case identification, contact tracing, clinical management, and public communications
      - Develop a test for the pathogen



Public Health System's Response—Challenges

- Global Challenges
  - Recent data indicates that asymptomatic cases are driving factor for transmission
  - Inadequate supply of personal protective equipment (PPE) and testing
  - Seasonality is expected to have a modest impact on transmission
- Challenges with U.S. Response
  - Slow to implement preventative measures
  - Issues with testing
    - Drawn out approval processes for both public and private labs to begin testing
    - Shortage of critical supplies like swabs and N95 masks
    - Shortage of testing kits
    - Faulty testing kits
  - Surge in demand is pushing U.S. health care system beyond its capacity

On the Horizon: Future Developments

- Interim Bill
  - Would address the new Paycheck Protection Program
  - Generally bipartisan support for allocating more money to small businesses
  - Tuesday, April 7: The White House requested an additional $250 billion for the loan program
  - Thursday, April 9: The Senate adjourned with no deal after stalemate
- Second CARES Act
  - Will likely be a few weeks until a fourth coronavirus bill is considered
  - Provisions may include benefits for the families of health care workers who have died in the pandemic, hazard pay for essential workers, and health care worker recruitment incentives
- Call for immediate relief and support for physician practices
  - American Medical Association Letter to Secretary Azar (April 7, 2020)
  - Requesting that HHS provide one month of revenue to each physician (MD or DO), nurse practitioner, and physician assistant enrolled in Medicare or Medicaid to account for financial losses and non-reimbursable expenses

On the Horizon: Future Developments

- Push for greater funding for rural providers
  - Concern that funding will not be distributed equitably to rural providers
  - Bipartisan group of 19 Senators urging HHS to consider the needs of rural hospitals, critical access hospitals and other rural providers as HHS distributes the $100 billion healthcare fund included in the *CARES Act*
- Reading tea leaves: A changed industry
  - Continued increased in telemedicine
  - Increased regulation on workplace sanitation, such as deep-cleaning or temperature checks
  - Potential for decreased regulation in other areas
  - Increased flexibility for sick leave
  - Changes to the U.S. public health system
  - Marketplace changes

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