

Expanded Medicare Payment Policy and CARES Act Provide Financial Relief for Healthcare Providers and Suppliers

Accelerated and advance payments, as well as higher reimbursement rates, aim to bridge the gap for US healthcare providers during COVID-19 crisis.

While US lawmakers and federal agencies have primarily focused on the treatment and prevention of COVID-19 in recent weeks, Congress and the Centers for Medicare & Medicaid Services (CMS) have moved in lockstep to also ease the financial impact of the pandemic on a variety of different healthcare providers and suppliers. First, on March 27, 2020, the President signed into law the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136 (the CARES Act) which provides, among other items, financial relief for healthcare providers and various sectors of the economy impacted by the COVID-19 pandemic. Within 24 hours, CMS issued specific guidance to implement an expanded payment program, authorized by the CARES Act, which enables Medicare providers and suppliers to obtain advance and accelerated payments to make up for lost revenue during the COVID-19 emergency.

With many healthcare providers and suppliers already experiencing financial distress due to additional resources needed to treat COVID-19 patients, as well as the deferment and cancellation of elective procedures, the actions of Congress and CMS may help providers and suppliers temporarily bridge the gap until regular operations may resume. This *Client Alert* focuses specifically on emergency financial relief measures directed at healthcare providers and suppliers by CMS and through the CARES Act.

Accelerated and Advance Medicare Payments for Providers and Suppliers

The expansion of Medicare's accelerated and advance payment program to all Medicare providers and suppliers will transition a historically regimented program into a nationwide opportunity for entities seeking financial support during a time of disruption caused by state lockdown orders and delays of elective procedures. In accordance with Section 3719 of the CARES Act, providers and suppliers may request an advance payment of 100% of their prior Medicare payment amount for either a three-month lookback period (for physicians, ambulatory surgery centers, DME suppliers, and home health agencies, among others), or a six-month lookback period (for most hospitals). Repayment of the advance payment will occur through recoupment of future claims. In light of the COVID-19 emergency, CMS also extended the recoupment and repayment timeline, allowing providers and suppliers to defer any recoupment of claims for 120 days after the payment is made. Repayment of final amounts after recoupment (if any remain) must be made within 210 days for most providers and suppliers, though hospitals generally will have up to one year to repay any remaining balance.

Requests for accelerated payment may be made to the appropriate Medicare Administrative Contractor (MAC) using the designated Accelerated / Advance Payment Request Form, available on the MAC's website, and must state the requested accelerated payment amount. CMS expects payments to be issued within seven days of receipt of the request. To qualify for accelerated payments, the provider must meet all of the following criteria:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the request form
- Not be in bankruptcy
- Not be under active medical review or program integrity investigation
- Not have any outstanding delinquent Medicare overpayments¹

Providers and suppliers impacted by the COVID-19 emergency should assess the potential benefits of applying for accelerated payments as an option to address near-term cash-flow challenges.

CARES Act Provisions Establish Other Financial Relief

In addition to this CMS program, the CARES Act adopted a number of other mechanisms intended to provide financial relief to healthcare providers and suppliers:

- **US\$127 Billion in Funding to Reimburse Expenses, Lost Revenue, and to Improve Virus Response**

The CARES Act appropriates US\$100 billion for the Public Health and Social Services Emergency Fund to reimburse healthcare providers for healthcare expenses or lost revenues attributable to coronavirus. The appropriation allows funds to be used on a pre-paid, prospective, or retrospective basis for surge capacity, construction of temporary structures, retrofitting facilities, property leases, supplies and equipment (including PPE) and testing supplies, as well as increased workforce and trainings. Eligible healthcare providers include public, for-profit, and nonprofit entities that "provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19."²

- **Suspension of Sequestration Payment Cuts**

Since April 1, 2013, Medicare fee-for-service payments have been subject to a 2% payment reduction ("sequestration") introduced by the Budget Control Act of 2011. The CARES Act suspends the 2% sequestration reduction to Medicare payments starting May 1, 2020 through December 31, 2020, resulting in increased payments to all Medicare providers and suppliers.³

- **Add-On Payment Under the Inpatient Prospective Payment System**

Under the inpatient prospective payment system (IPPS), providers will receive a 20% increase to the weighting factor for each diagnosis-related group (DRG) for individuals with a diagnosis of COVID-19 during the emergency period.⁴

- **Payment Adjustment for DME Suppliers**

Under existing regulation, CMS applies a blended payment rate for DME furnished in rural or non-contiguous competitive bidding areas. Through December 31, 2020, that blended rate would be equal to 50% of the adjusted fee schedule amount (adjusted based on competitively bid prices) and 50% of the unadjusted DMEPOS fee schedule amount. DME furnished in non-rural or

contiguous areas would not have been eligible for this blended rate, and instead many suppliers would have experienced a reduced payment rate that reflected competitively bid prices.

The CARES Act extends the 50% blended rate for rural / non-contiguous areas through December 31, 2020 or until the end of the emergency period (if longer). The Act also introduces a new blended rate for non-rural / contiguous areas equal to 75% of the adjusted fee schedule amount and 25% of the non-adjusted fee schedule amount.⁵

- **Extension of Rate Caps and Delayed Reporting for Laboratory Tests Required Under PAMA**

Under the Protecting Access to Medicare Act of 2014 (PAMA), certain laboratory test suppliers are required to report to CMS the payment rates received from private payors and test volumes furnished to private plans, and CMS uses these reported rates and volume information to adjust Medicare payment rates for clinical diagnostic laboratory tests (CDLTs). The CARES Act adopted a one-year delay for the obligation to report payment rates and volumes for CDLTs and advanced diagnostic laboratory tests, such that reporting will not be required until January 1, 2022. The Act also provides that no PAMA-based payment reductions for laboratory tests will occur during the 2021 fee schedule year, ensuring stability in current payment rates.⁶

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Endnotes

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- ¹ See CMS, Trump Administration Provides Financial Relief for Medicare Providers (Mar. 28, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers>
 - ² See CARES Act, at 750.
 - ³ See *id.* § 3709.
 - ⁴ See *id.* § 3710.
 - ⁵ See *id.* § 3712.
 - ⁶ See *id.* § 3718.