Recent COVID-19 Stimulus Legislation and Guidance: Opportunities and Considerations for States

Friday, May 1, 2020
2:00-3:00 pm ET

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at [www.shvs.org](http://www.shvs.org).
COVID-19 Resources for States

State Health and Value Strategies has created an accessible one-stop source of COVID-19 information for states at www.shvs.org/covid19/. The webpage is designed to support states seeking to make coverage and essential services available to all of their residents, especially high-risk and vulnerable people, during the COVID-19 pandemic.
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Agenda

- Timeline of the Recent Federal Response to the COVID-19 Public Health Emergency

- Summary of Recent Federal Stimulus Legislation and Guidance
  - Treasury Guidance on Coronavirus Relief Fund
  - “CARES Act 3.5”
  - Provider Relief Fund
    - HHS Disbursement Approach
    - Balance Billing Conditions

- Update on Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis

- Questions
Timeline of the Federal Response to the COVID-19 Public Health Emergency
Timeline of Recent Federal Response to COVID-19 Crisis

- **March 27**: Coronavirus, Aid and Economic Relief (CARES) Act signed into law
- **April 3**: Paycheck Protection Program loan applications open
- **April 10**: Initial $30B of Provider Relief Fund distributed
- **April 16**: Funding runs out for Paycheck Protection Program
- **April 22**: HHS releases additional details on plans to distribute remaining Provider Relief Funds
- **April 24**: “CARES 3.5” (Paycheck Protection Program and Health Care Enhancement) Act signed into law
- **April 27**: HHS begins to distribute next $20B of Provider Relief Fund and opens portal for providers to receive reimbursement for uninsured claims
Legislation in March and April 2020 created new funding opportunities for states and providers to respond to the COVID-19 crisis. Below is a high-level summary of key funding sources, but is not a comprehensive summary of the funding in each.

**Health Care Related Funding**
- CARES Act Funding
- Coronavirus Relief Fund ($150 Billion)
- Provider Relief Fund ($100 Billion)
- Small Business Paycheck Protection Program ($349 Billion)

**Non-Health Care Related Funding**
- (e.g., stimulus checks)

**Select Funding Opportunities for States/Localities**
- Coronavirus Relief Fund ($150 Billion)

**Select Funding Opportunities Providers**
- Provider Relief Fund ($100 Billion)

**“CARES Act 3.5”**
- Provider Relief Fund ($75 Billion)
- COVID-19 Testing Fund ($25 Billion)
- Small Business Paycheck Protection Program ($321 Billion)
Treasury Guidance on Permissible Uses of Coronavirus Relief Fund
Overview: The Coronavirus Relief Fund

- The CARES Act established the $150B fund Coronavirus Relief Fund (CRF) for states, tribal governments and local governments with populations of 500,000 or more. Key features include:
  - $8B reserved for tribal governments, $3B reserved for DC and the territories
  - Funding is distributed by the Treasury in proportion to state population, with a floor of $1.25B per state; local governments may receive up to 45% of state allocation

- This funding may only be used to cover costs that:
  - Are necessary expenditures incurred due to the COVID-19 public health emergency;
  - Were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the State or local governments; and,
  - Were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020.
On April 22, the Department of the Treasury released additional details on permissible and impermissible uses of the Coronavirus Relief Fund in the form of guidance and FAQs.

<table>
<thead>
<tr>
<th>Category of Spending</th>
<th>Examples</th>
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<tbody>
<tr>
<td><strong>Sample Permissible Uses</strong></td>
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<tr>
<td>Medical Expenses</td>
<td>✓ Establishing temporary public medical facilities, including construction costs</td>
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<td>Public Health Expenses</td>
<td>✓ Expenses to facilitate compliance with public health measures, such as:</td>
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<td>✓ Food delivery to residents, including vulnerable populations</td>
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<td>✓ Technology improvements for distance learning</td>
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<td>✓ Payroll expenses for public safety, public health, health care, human services, and “similar” employees whose services are substantially dedicated to mitigating or responding to public health emergency</td>
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<td>Economic Support</td>
<td>✓ Grants to small businesses to reimburse the costs of business interruption caused by required closures</td>
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<td>Other</td>
<td>✓ State costs that are substantially different from expected based on budgets approved as of March 27</td>
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<td></td>
<td>✓ COVID-19 related appropriations enacted prior to March 27</td>
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<tr>
<th><strong>Sample Impermissible Uses</strong></th>
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<tbody>
<tr>
<td>X Medicaid state share</td>
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<tr>
<td>X Expenses reimbursable under any federal program, such as state contributions to unemployment funds (the reimbursement for which is provided by the CARES Act)</td>
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<td>X Legal settlements</td>
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CRF Distribution Guidance: Key Questions for States

- What level of scrutiny will be applied to a state’s CRF spending decisions? How will the Treasury validate the “necessary” expenditure standard?
- To what extent can the Coronavirus Relief Fund be used indirectly to replace lost revenues?
- How should states and local governments analyze the availability and level of other reimbursement for expenditures (e.g., FEMA funding)?
- How should states collect data and relevant information from providers on their use of other non-Coronavirus Relief Fund funding (e.g., direct funding from the Provider Relief Fund) to avoid duplication of funds?
- What information and data will states be required to report on?
“CARES Act 3.5”
Paycheck Protection Program and Health Care Enhancement Act
Enactment of the “CARES Act 3.5” Stimulus Package

On April 24, the **Paycheck Protection Program and Health Care Enhancement Act**, was signed into law (P.L. 116-139)

This $484 billion legislation has become known as “CARES Act 3.5” because it generally replenishes funding that was first established in the CARES Act (P.L. 116-136), enacted on March 27

The legislation provides additional funding for COVID-19 testing, additional Provider Relief Funds and new funds for the Paycheck Protection Program for small businesses
Deep Dive: Additional Funds Added to Provider Relief Fund

Summary of Key Provisions

- **Adds $75 billion** to the Provider Relief Fund established by the CARES to directly reimburse providers for expenses/lost revenues attributable to COVID-19 and not otherwise reimbursable. Other than increasing the amount of the fund to a new total of **$175 billion**, no other changes were made to the legislative language.

  ✓ **Potential Recipients:** Medicare or Medicaid enrolled providers, and for-profit and not-for-profit entities within the United States that provide diagnosis, treatment, and care for possible or actual cases of COVID-19.

  ✓ **Potential Uses:** Building or construction of temporary structures, leasing of properties, medical supplies and equipment, increased workforce and trainings, emergency operation centers, retrofitting facilities, surge capacity, reimbursement for COVID-19 testing and treatment of the uninsured and lost revenues due to the COVID-19 crisis.

**Key Insights for States**

To date, distributions from the Provider Relief Fund have focused on quickly getting money to Medicare providers and generally distributed dollars based on each such provider’s historic net revenue. HHS has not yet reserved a specific $ amount for providers who predominantly serve Medicaid/uninsured or taken any steps to target resources at providers with greatest COVID-driven fiscal challenges.

**States will need to engage to ensure that a share of the new $75B for the Provider Relief Fund by CARES 3.5 is targeted to Medicaid providers.**
Deep Dive: Funding for COVID-19 Testing

Summary of Key Provisions

- CARES Act 3.5 establishes $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for both active infection and prior exposure COVID-19 tests. The Act specifies that funding may be used for grants for a range of testing supports including:
  
  - **Testing infrastructure and supplies** (e.g., rent or equipping facilities to improve preparedness and response capacity for COVID-19 testing)
  
  - **Testing production** (e.g., equipping facilities for production of COVID-19 testing supplies)
  
  - **Personal protective equipment (PPE) and testing supplies** (e.g., purchase of medical supplies and equipment)
  
  - **Workforce** (e.g., new workforce or training for providers)

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<th>Key Components of $25 Billion COVID-19 Testing Fund</th>
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<td><strong>Recipient</strong></td>
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<td>States, Localities and Tribal Organizations</td>
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<tr>
<td>Health Centers &amp; Rural Health Clinics</td>
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<tr>
<td>Testing for Uninsured</td>
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<tr>
<td>Department/ Agency Appropriations</td>
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HHS must submit to Congress a report to Congress of individuals tested for or diagnosed with COVID-19 that includes demographic data—race, ethnicity, age, sex and geographic region.
Deep Dive: Testing and Treatment for the Uninsured

Recent COVID-19 related legislation has established options for COVID-19 testing and treatment of the uninsured. HRSA is likely to administer the majority of these funds, and be responsible for identifying which funding stream to draw from, based on the type of claim received (e.g., claims for COVID-19 testing vs COVID-19 treatment).

**Families First Coronavirus Response Act (FFCRA)**

- **New Optional Medicaid Eligibility Group**
  - Makes available a new optional “COVID-19 Testing” Medicaid eligibility group

  - **FFCRA Relief Fund ($1B)**
    - Reimburses providers for testing and testing-related services only for uninsured individuals

- HRSA will distribute funds through a claims-based system for testing only directly to registered providers, paid at Medicare rates

**CARES Act**

- **Provider Relief Fund ($100B)**
  - Funding to providers for lost revenues. An unspecified portion of the fund will be used to cover testing and treatment for the uninsured

- **Coronavirus Relief Fund ($150B)**
  - Funding to states, local governments and tribes, a portion of which may be used to cover COVID-19 testing and treatment

- HRSA will administer to reimburse providers for testing and treatment through the establishment of an “Uninsured Relief Fund,” paid through a claims based system at Medicare rates

**“CARES Act 3.5”**

- **Provider Relief Fund ($75B)**
  - Funding to providers for lost revenues.
  - Distribution details are TBD, but may be used to cover testing and testing-related services for the uninsured

- **COVID Testing and Treatment Fund ($25B)**
  - Funding for COVID-19 testing and treatment.
  - Up to $1B must be used to cover testing and testing-related services for the uninsured

- HRSA will distribute funds through a claims-based system for testing only directly to registered providers, paid at Medicare rates
Deep Dive: Small Business Programs

Summary of Key Provisions

- CARES Act 3.5 appropriates **an additional $381 billion** for small business loans and related expenses which could support some small health care providers.
  - The funds provided for these loan and grant programs in the CARES Act were insufficient to meet the large need, and many small businesses were shut out with applications still pending.

Key Funding Streams

- **Paycheck Protection Program ($321B)**
  - Replenishes CARES Act loan funding for small businesses and requires that $60 billion of loans be made by small, community-based financial institutions.
  - Brings total funding to $670B

- **Economic Injury Disaster (EIDL) Grants Program ($10B)**
  - Replenishes EIDL Program established under CARES Act

- **Disaster Loans Program Account ($50B)**
  - Replenishes Disaster Loans Program Account established under CARES Act

Applications for loan funding re-opened on 4/27
CARES Act
Provider Relief Fund
The Provider Relief Fund: Timeline of Actions to Date

March 23:
CARES Act passes, establishing $100 Provider Relief Fund

April 10:
HHS announces and begins distributing the first $30 billion (based on providers’ share of Medicare fee-for-service payments in 2019)

April 22:
HHS announces plan for distributing the majority of the remaining $70 billion in the enacted Provider Relief Fund

April 23:
Congress passes “CARES Act 3.5,” including an additional $75 billion for the Provider Relief Fund

Week of 4/27
HHS begins to distribute portion of remaining funds

“CARES 3.5” maintains the same requirements with respect to HHS distribution of the funding; distribution of the $75 billion among providers is at HHS discretion.
## What We Know: Distribution of the $175B Provider Relief Fund

| $50 Billion General Fund | $30 billion to Medicare providers based on their share of total 2019 Medicare fee-for-service expenditures *(Distributed April 10 and April 17)*  

*HHS has stated it intends to distribute the remaining $20 billion in a similar manner, based on 2018 net patient revenue but mechanics to balance overall funding remain unclear.*  

$20 billion based on 2018 net patient revenue from all payers *(Began distributing on April 27, on a weekly, rolling basis)* |
|---|---|
| $10 Billion for Hotspots | $10 billion “targeted to hospitals in areas that have been particularly impacted by COVID-19.” HHS also will “take into consideration” hospitals’ Medicare DSH adjustment  

*Hospitals “applied” for the funds by providing, through the provider portal, their TIN, NPI, total number of ICU beds as of 4/10, and total number of admissions with a positive diagnosis for COVID-19 from 1/1-4/10* |
| $10 Billion for Rural Providers | $10 billion for rural health clinics and hospitals, distributed based on operating expenses |
| $400 million for Indian Health Service (IHS) | $400 million for Indian Health Services facilities, distributed based on operating expenses |
| COVID-19 Uninsured Claims | Unspecified amount based on claims submitted to HHS by providers for testing or treating uninsured COVID-19 patients on or after 2/4 (reimbursed at Medicare rates)  

*Providers can register for the program beginning April 27 and reimbursement expected to begin mid-May* |
| TBD | “Additional allocations” for skilled nursing facilities, dentists, and providers that solely take Medicaid |
| $75 Billion from CARES Act 3.5 | *No additional guidance has been given by HHS to date on how these funds will be distributed* |
Provider Relief Fund Distribution: Key Questions for States

- To what extent does the current methodology for the Provider Relief Fund leave out Medicaid providers that otherwise will turn to states for support?
  - Share of Medicare providers also enrolled in Medicaid, across various provider types
  - Size of payment rate gap between Medicaid and other payers included in “net revenues”
- What are the implications of the current distribution methodology for the short and long-term viability of Medicaid provider networks? For low-income Medicaid beneficiaries?
- What are priorities for the new $75 billion in the Provider Relief Fund? What factors should HHS consider when distributing these dollars?
  - Funding specifically for providers serving a significant share of Medicaid and uninsured?
  - What should be the eligibility criteria for any such set aside? How should any such set aside be distributed?
  - What role should states play in the distribution of Provider Relief Fund dollars?
- What role should or could states play in advising HHS on the distribution of the new $75 billion?

State Insight: Rachel Pryor
Deputy Director for Administration
Virginia Department of Medical Assistance Services
Provider Relief Fund Balance Billing Conditions

- Provider Relief Funds are conditioned on provider agreement not to collect from patients anything more than would have been collected if service was in network.
- Applies to “presumptive or actual COVID-19 patients”
Provider Fund Balance Billing Conditions: Provider and State Issues and Considerations

Key Questions for States

- **Questions on Breadth of Protection**
  - Are all patients covered? (Evaluation visit, diagnostic test, treatment?)
  - Which providers are banned from balance billing?
  - Can consumers be required to pay upfront?
  - What will out-of-network providers be paid?
  - How can the balance billing ban be enforced?
Provider Fund Balance Billing Conditions: Provider and State Issues and Considerations (Cont’d)

Intersection with State Laws

• State surprise billing laws in place in 29 states
  – 15 with comprehensive protections

• COVID-related measures in several states
  – Bulletins reminding providers and insurers of existing laws or urging them not to balance bill
  – New actions to add emergency protections

• Interactions
  – Does federal requirement for paying labs preempt state payment standards or dispute resolutions process?
  – Does state standard apply with regard to ban on provider balance billing?
Update on Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis
Reminder: Strategies to Increase Medicaid Payments to Providers

1. Increase payments to providers with declining utilization
2. Make directed payments to providers
3. Make pass-through payments to essential at-risk providers
4. Make advanced, interim payments to providers with reconciliation
5. Set base rates to match last year’s costs
6. Adjust UPL calculation to preserve aggregate payment levels

*For discussion today*
Status Update: New Hampshire and North Carolina’s Strategies to Sustain Providers

New Hampshire: Directed Payments

- Establish a pool for directed payments, set at approximately 1.5 percent of capitated payments and distributed to essential providers
- Adopt new risk corridors for current plan year
- Remove managed care withholds, acknowledging MCO efforts to stabilize provider networks
- Requires CMS approval of directed payment SPA and approval of updated actuarial certification

North Carolina: Payments to Providers

- Doubling PMPMs to primary care practices serving as a medical home for Medicaid recipients during the COVID-19 public health emergency
- Making retainer payments to HCBS providers who are unable to provide services as a result of the pandemic
- Providing advanced payments to providers
- Making enhanced payments to SNFs with COVID-19 patients to reflect higher current costs

Status Update: Henry Lipman, New Hampshire Medicaid Director

Status Update: Julia Lerche, Chief Strategy Officer and Chief Actuary, North Carolina Medicaid
Questions?

The slides and a recording of the webinar will be available at www.shvs.org after the webinar
Reference Legislation Guidance and Citations

**Enacted Legislation**


- **H.R. 266/ P.L. 116-139**: Paycheck Protection Program and Health Care Enhancement Act. **Available:** [https://www.congress.gov/116/bills/hr266/BILLS-116hr266enr.pdf](https://www.congress.gov/116/bills/hr266/BILLS-116hr266enr.pdf)

**Federal Guidance**


**Other Relevant Citations**

