

## COVID-19

### The Federal Government's Response to the Coronavirus (COVID-19) Pandemic: Questions & Answers

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#### Introduction

In response to the COVID-19 pandemic, the federal government is moving rapidly to help states and health care providers respond to mounting needs for new sources of funding and flexibility. Congress has passed three COVID-19 stimulus bills, which authorize programmatic changes in Medicare, Medicaid, and Marketplace coverage and also appropriate billions of dollars to support states, localities, and health care providers. For example, the most recent bill, the Coronavirus Aid, Relief, and Economic Security (CARES) Act ([P.L. 116-136](#)) includes a \$100 billion Provider Relief Fund to help cover health care related expenses or lost revenues that are attributable to COVID-19.

In addition, the U.S. Department of Health and Human Services (HHS)—and its component agencies, including the Centers for Medicare & Medicaid Services (CMS)—has issued voluminous guidance outlining new flexibilities available to states and providers, and is working at breakneck speed to approve additional requests from states, to award funds appropriated by Congress, and to issue more guidance about such funding. This Q&A provides a moment-in-time update in response to questions SHVS has received about the federal government's response.

**1. Question: *Do you have any insight into how the \$100 billion for providers included in the CARES Act will be distributed?***

**Answer:** The CARES Act created a \$100 billion Provider Relief Fund to cover health care related expenses or lost revenues that are attributable to COVID-19. On April 10, HHS [distributed](#) an initial \$30 billion tranche of funding to providers based on *Medicare* fee-for-service (FFS) revenue; this approach was designed to quickly deliver funding to hospitals and other providers through established payment mechanisms, without the need for any application to HHS. Details about how the remaining \$70 billion will be distributed have not been released as of this writing, but HHS has described its broad plans for distributing the remainder. First, HHS is considering how to distribute funding to other providers who receive the majority of their revenue from Medicaid or other non-Medicare sources, such as pediatricians, children's hospitals, obstetrician-gynecologists (OBGYNs), and nursing homes as well as to providers in areas particularly hard-hit by COVID-19. The Administration also [announced](#) that a yet-to-be determined portion of the funding will be used to directly reimburse hospitals for COVID-19-related care of uninsured patients. HHS Secretary Azar indicated that providers will be reimbursed at Medicare rates and will be prohibited from balance

billing, or charging patients for expenses not reimbursed by insurance. Additional guidance is expected soon.

**2. Question: *Does "testing-related services" include appropriate treatment if the test is positive?***

**Answer:** No. CMS clarified in its April 13 [Frequently Asked Questions](#) (FAQs) document that "testing-related services" do not include appropriate treatment if a COVID-19 test is positive. This means that in states that elect to cover the new "COVID-19 testing" optional uninsured Medicaid eligibility group [established in new section 1902(a)(10)(A)(ii)(XXIII)], testing and testing-related services are covered—and matched by the federal government at 100 percent of state costs—but treatment is not covered. For other populations covered by Medicaid, however, for any quarter in which the temporary increased Medicaid matching rate is claimed, states must cover, under the state plan (or waiver), testing services *and* treatments for COVID-19, including vaccines, specialized equipment, and therapies, without cost-sharing. Therefore, even though the definition of testing-related services appears to be narrow, the condition that Congress placed on receipt of the increased Medicaid matching rate assures that most individuals enrolled in Medicaid (other than the new COVID-19 testing group) will receive coverage for appropriate treatment, without cost sharing.

**3. Question: *If there is no income eligibility limit for uninsured individuals to have certain services covered in Medicaid under the new stimulus legislative authority, how will that impact enrollment in the Marketplace?***

**Answer:** The new optional Medicaid COVID-19 testing group allows states to cover testing and testing-related services for uninsured individuals, defined as individuals who are not otherwise eligible for public or commercial health care coverage.<sup>1</sup> Although there is no income limit for this group, they only receive COVID-19 testing and testing-related services, not treatment. Thus, uninsured individuals eligible to enroll in Marketplace coverage through a special enrollment period will receive a more comprehensive benefit package through the Marketplace than they would in the new COVID-19 testing group. Individuals who receive testing services under the optional Medicaid COVID-19 testing group could still enroll in Marketplace coverage because their limited Medicaid coverage is not likely to be considered [minimal essential coverage](#).

In [FAQs](#) issued on April 13, CMS advises that uninsured individuals who apply for coverage through the regular single, streamlined application and are determined ineligible for other full-benefit Medicaid eligibility groups should be screened for potential eligibility for Marketplace coverage. Even though states do not have to assess all other bases of eligibility before enrolling an individual in the COVID-19 testing group, CMS suggests that states should inform individuals seeking coverage in the COVID-19 testing group that they may be eligible for comprehensive benefits through Medicaid or the Marketplace. Therefore, in states that adopt the new optional COVID-19 testing group, it is likely that some individuals could get tested immediately for COVID-19, with no cost-sharing, but later enroll in Marketplace coverage for treatment.

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<sup>1</sup> In general, to be eligible for the COVID-19 testing group, individuals must not be enrolled in Medicaid coverage, except that individuals who are enrolled in a limited benefit Medicaid eligibility group will not be considered to be enrolled in health coverage as a result of such enrollment and are therefore eligible for the new group.

4. **Question:** *Regarding the guidance on extending grace periods, would a state mandating issuers suspend all terminations supersede the CMS guidance stating that all those already in grace periods would still be terminated at the end of the current, applicable grace period?*

**Answer:** On March 24, CMS issued [guidance](#) that permits qualified health plan (QHP) issuers, subject to state approval, to extend premium payment deadlines, including delaying the beginning of an applicable grace period. CMS said that this would permit the delay of the beginning of the 90-day federally-required grace period for QHP enrollees that receive advance payment of premium tax credits (APTCs). The CMS guidance continues: “Once a grace period is triggered, however, the basic requirements applicable to the grace period would remain unchanged” and, when “the three-month grace period expires, issuers must notify HHS of terminations for non-payment, which will result in issuers’ return of APTC for the second and third months of an exhausted grace period.” State insurance regulators have applied this guidance in various ways. On April 6, the Maine insurance superintendent issued an [order](#) that said, in addition to delaying the start of any new grace periods, “For any policyholder receiving APTC who is currently in a grace period, the carrier must terminate that grace period by unconditionally withdrawing the notice of cancellation and unconditionally reinstating coverage.” Colorado has circulated a draft insurance [bulletin](#) for informal public comment that would require insurers to delay the start of all grace periods in the individual market until 30 days after the Governor’s COVID-19 emergency order ends. The draft bulletin would also require insurers to suspend any previously issued cancellation notices for non-payment of premium.

5. **Question:** *How does the magnitude of federal support stemming from recently-adopted legislation compare to increasing demands on Medicaid and the Children's Health Insurance Program (CHIP)?*

**Answer:** Through the three federal stimulus bills enacted to date, Congress has adopted various measures to provide supplemental funding to states, local governments and providers to address the COVID-19 crisis. This includes, but is not limited to, the 6.2 percentage point increase in Federal Medical Assistance Percentages (FMAP) for selected Medicaid expenditures in the Families First Coronavirus Response Act (FFCRA), \$1.4 billion in additional funding for community health centers, the CARES Act’s \$100 billion provider relief fund, and other targeted health care funding. The CARES Act also created a \$150 billion Coronavirus Relief Fund for states and local governments, which could be used to support growing health care needs.

While these new COVID-19-related resources are substantial, they are unlikely to be enough to match the growing need for state and local resources due to COVID-19 treatment costs, maintaining continuous coverage for current Medicaid enrollees, increasing Medicaid and CHIP enrollment, and declining state revenues that will threaten states’ ability to sustain these important programs. Of particular note, the economic and fiscal impact of the COVID-19 crisis now is expected to last longer than the pandemic itself, placing extended pressure on Medicaid and CHIP budgets. The Congressional Budget Office, for example, [projects](#) that the country will be facing an unemployment rate of close to nine percent in December of 2021, nearly two years after the start of the pandemic. Along with higher Medicaid and CHIP enrollment, such conditions will drive significant [declines](#) in state tax [revenue](#). For context, earlier recessions [indicate](#) that a one percentage point increase in the unemployment rate is associated with a \$40 billion drop in tax revenue. In light of these conditions and the unprecedented economic impact of the pandemic, it is important to prepare for extended pressure on Medicaid and CHIP budgets. As a result, Congress is already debating taking

further action to provide additional COVID-19 resources and fiscal relief to state and local governments.

**6. Question: *Should states expect a fourth stimulus package? Will the FMAP increase be expanded or extended?***

**Answer:** It's highly likely that Congress will take action in the form of a fourth COVID-19 stimulus package, though the timing is uncertain and is likely to slip into May. More immediately, Congress remains focused on the potential for a "COVID 3.5" bill to provide additional funding for programs previously passed as part of the CARES Act. Such a bill—which Congress would aim to pass by unanimous consent before returning to Washington, D.C.—would supplement CARES Act funding for businesses, states, localities, and/or providers and would not include new policies.

A fourth stimulus package could include an expansion or extension of the 6.2 percentage point FMAP increase provided by FFCRA. That increase is available for each calendar quarter occurring during the public health emergency. [States](#) and stakeholders have already begun asking Congress to consider an increase (to yield a 12 percentage point increase in the FMAP) and to extend the increase beyond the end of the public health emergency to help states respond to economic conditions caused by the pandemic. Extending the FMAP increase would help cash-strapped states avoid a "fiscal cliff" at the end of the public health emergency period, particularly since program enrollment is expected to continue to grow. During the Great Recession, the American Recovery and Reinvestment Act (ARRA) (and subsequent legislation extending ARRA's original increased FMAP provision) provided 11 quarters of federal fiscal relief. Under ARRA, states qualified for a 6.2 percentage point increase *plus* an additional increase in FMAP based on the increase in a state's unemployment rate, bringing states' average FMAP increase up by almost 10 percent. To respond to the current crisis—which could be longer and deeper than the Great Recession—Congress could consider modifying the original FFCRA increase to reflect unemployment or other economic indicators.

As of this writing, it is unclear how amenable Congress will be to expanding and extending the FMAP increase, but pressure from states and other stakeholders is likely to grow as the economic impact of the pandemic continues to unfold.

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