Congressional Relief Legislation in Response to COVID-19

In response to the COVID-19 crisis, Congress has passed three relief packages to date. Highlighted below are legislative provisions of interest to children’s hospitals within the different packages. We will continue to update this document as additional information becomes available, such as relevant information from agencies on the implementation of these provisions, or if Congress enacts additional relief.

Package 3: Coronavirus Aid, Relief, and Economic Security Act or the CARES Act

H.R. 748

Signed by the President March 27, the CARES act includes approximately $2 trillion in emergency funding to respond to the public health and economic impact of the pandemic.

Public Health and Social Services Emergency Fund:

- Provides $100 billion for a Public Health and Social Services Emergency Fund intended to reimburse eligible hospitals, including children’s hospitals, and other providers for health care related expenses attributable to COVID-19 not covered through other sources of funding—including lost revenues. Eligible providers will directly submit applications to the Secretary that include a statement justifying the need of the provider for the payment. The bill does not provide extensive details on the precise allocation method for the funding, noting that the Secretary of Health and Human Services shall make payment on a rolling basis, and payments shall be made “in consideration of the most efficient payment systems practicable.”

Medicaid:

- Eliminates Medicaid Disproportionate Share Hospital (DSH) cuts for FY 2020, a total of $4 billion, and reduces the cuts in FY 2021 from $8 billion to $4 billion. The onset of any FY 2021 cuts is delayed from Oct. 1, 2020, to Dec. 1, 2020. Congress will need to act by Dec. 1 to prevent the start of FY 2021 cuts.
- Delays the application of the maintenance of effort (MOE) requirement that restricted states from increasing premiums as a condition of receiving the temporary FMAP increase, as authorized by Families First Coronavirus Response Act. The MOE would not take effect for 30 days from date of enactment if a state had in effect a premium increase as of the date of enactment.
- Clarifies a section of the Families First Coronavirus Response Act that ensures uninsured individuals can receive a COVID-19 test and related services with no cost-sharing in any state Medicaid program that chooses to offer the option.
- Extends funding for the Medicaid Money Follows the Person demonstration program, spousal impoverishment provisions, and Community Mental Health Services demonstration program through Nov. 30, 2020. The Community Mental Health Services demonstration will also be authorized to expand to two additional states.
- Directs the Government Accountability Office (GAO) to issue a study and report on the Community and Mental Health Services Demonstration Program within 18 months of enactment of this legislation.
• Allows state Medicaid programs to provide home and community-based support services in a hospital setting through payment for direct support professionals and caregivers trained to assist with activities of daily living with a focus on reducing length of stay.

• Clarifies that federal pandemic unemployment compensation will not affect eligibility for Medicaid or CHIP.

**Relevant Health Provisions:**

• Extends funding for community health centers, the Special Diabetes Program, the National Health Service Corps, and teaching health centers through Nov. 30, 2020.

• Provides **$27 billion** for the Biomedical Advanced Research and Development Authority for research and development of vaccines and therapeutics to fight the virus and other medical needs.

• Provides **$4.3 billion** to the CDC—includes **$1.5 billion** in grants to state and local governments and tribes to carry out surveillance and laboratory testing, infection control and other activities, and **$500 million** for public health data surveillance and analytics infrastructure modernization.

• Provides **$706,000,000** to the National Institute of Allergy and Infectious Diseases—includes **$156,000,000** dedicated funds to construction, renovation and acquisition of equipment for vaccine and infectious disease facilities.

• Provides **$1.32 billion** in supplemental funding to community health centers to help treat COVID-19 patients.

• Provides **$45 billion** for the Federal Emergency Management Agency Disaster Relief Fund designed to support state and local efforts to recover from the pandemic, including medical response and protective equipment.

**Aid to States:**

• Provides a **$150 billion** Coronavirus Relief Fund for state, territorial, tribal and local governments—$11 billion will go to tribal government and territories. States may use these funds to cover costs for necessary expenditures incurred due to the public health emergency and for expenses not accounted for in the most recent past state budget. These expenses must be incurred during March 1, 2020, through Dec. 30, 2020.

**Telehealth:**

• Reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services.

• Allows health savings accounts with a high deductible plan to be used to pay for telehealth services prior to a patient reaching that deductible

• Requires HHS to issue clarifying guidance to encourage the use of telecommunications systems—including remote patient monitoring—to provide home health services under the Medicare program consistent with the patient’s care plan.

**COVID-19 Coverage:**

• Clarifies that non-expansion states can use the Medicaid program to cover COVID-19 related services for uninsured adults who would have qualified for Medicaid if the state had chosen to expand. It also clarifies that other populations with limited Medicaid coverage, such as impoverished pregnant women and individuals who are eligible because they have certain health conditions, also are eligible for coverage under this state option.
• Clarifies that all testing for COVID-19 is to be covered by private insurance plans without cost sharing, including tests provided by labs on an emergency basis, state-developed tests, and any other tests determined appropriate by HHS. Requires private insurers to reimburse a test provider the negotiated in-network rate. In cases where the test provider is out-of-network, the plan must pay the “cash price” listed on a public website. Establishes a $300/day monetary penalty for providers that do not make their prices for testing public.

• Provides free coverage without cost-sharing of a vaccine within 15 days for COVID-19 that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force or a recommendation from the Advisory Committee on Immunization Practices (ACIP).

**Workforce Provisions:**

• Reauthorizes health professions workforce programs included in Title VII of the Public Health Service Act.

• Establishes a “Ready Reserve Corps” to ensure there are trained doctors and nurses to respond to COVID-19 and additional public health emergencies.

• Allows the Secretary of HHS to reassign members of the National Health Service Corps in order to respond to the COVID-19 public health emergency.

• Clarifies that health care professionals who provide volunteer medical services during the public health emergency related to COVID-19 have liability protections.

• Reauthorizes and updates nurse workforce training program included in Title VIII of the Public Health Service Act.

• Extends the Health Professions Opportunity Grants program until Nov. 20, 2020. These grants provide education and training to TANF recipients and other low-income individuals for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand.

• Requires the Secretary of HHS to consult the Advisory Committee on Training in Primary Care Medicine and Dentistry and the Advisory Council on Graduate Medical Education to develop a comprehensive plan with respect to health care workforce development programs, including education and training programs.

**Drug & Device Provisions:**

• Provides up to $16 billion to be used to replenish the Strategic National Stockpile with medical supplies, including drugs and protective equipment.

• Clarifies that the Strategic National Stockpile can stockpile medical supplies, such as the swabs necessary for diagnostic testing for COVID-19.

• Includes provisions of the MEDS act: provides FDA additional authority to address drug shortages through 1) prioritizing and expediting the review of drug applications and inspections to prevent or mitigate shortages 2) strengthening manufacturing reporting requirements when there is an interruption in supply, including rationale, expected duration, and information about active pharmaceutical ingredients (APIs) when APIs are the cause of the interruption—including source and known alternative sources—and 3) requiring manufacturers to maintain contingency, or “redundancy risk management plans,” to ensure a backup supply of products. Furthermore, requires manufacturers to provide information about drug volume, i.e., amount of each drug for commercial distribution. CHA has been supportive of this legislation and actively lobbied on it.
• Provides **$80 million** to the FDA for work related to shortages of critical medicines, emergency use authorizations and pre- and post-market work on medical countermeasures, therapies, vaccines and research.

• Provides **$1 billion** to the Defense Department to invest in manufacturing capabilities in order to increase production of personal protective equipment and medical equipment to meet the demand of healthcare workers nationwide.

• Directs the National Academies to study the manufacturing supply chain of drugs and medical devices and provide Congress with recommendations to strengthen the U.S. manufacturing supply chain. The report would emphasize critical drugs and devices and provide recommendations on redundancy, domestic manufacturing and improved information sharing to mitigate disruptions in the future.

• Establishes an over-the-counter drug user fee to increase FDA oversight. This provision is supported by the FDA and will allow for additional drug monographs to be approved—the current process is outdated. Many current labels are confusing for parents and can easily lead to incorrect dosing for kids.

• Requires an annual update to Congress regarding FDA’s progress in evaluating certain pediatric indications for certain cough and cold monograph drugs for children under age 6. Pediatric experts have long raised concerns around the dangers of cough medicine and this provision is positive step.

• Clarifies that medical device manufacturers are required to submit information about a device shortage or device component shortage upon FDA request. Also allows for expedited inspection and review to curb any potential shortages.

• Provides Breakthrough Therapy designations for animal drugs that can prevent human diseases.

• Allows patients to use funds in HSAs and Flexible Spending Accounts for the purchase of over-the-counter medical products, including those needed in quarantine and social distancing, without a prescription from a physician.

**Medicare Sections of Interest:**

• Eliminates the Medicare sequester from May 1 through Dec. 31, 2020.

• Includes a **20% increase** in Medicare hospital payments for care of COVID-19 patients.

• Allows acute care hospitals flexibility during the COVID-19 emergency period to transfer patients out of their facilities and into alternative care settings in order to prioritize resources needed to treat COVID-19 cases.

• Expands the Medicare accelerated payments program for a number of hospital types as defined in Medicare statute, including children’s hospitals. Qualified facilities would be able to request up to a six-month advanced lump sum or periodic payment. Most hospitals could elect to receive up to 100% of the prior period payments, or up to 125% in the case of Critical Access Hospitals. Hospitals would have at least 12 months to complete repayment with interest requirements.

**Privacy Provisions:**

• Requires HHS to issue guidance on what is allowed to be shared of patient records during the public health emergency related to COVID-19.

• Allows records pertaining to substance use disorder (SUD) treatment or activities to be used or disclosed to covered entities for the purposes of treatment, payment or health care operations as permitted by HIPAA once a patient’s written consent is obtained. Also allows disclosures of de-identified health information from these records to public health authorities as defined by HIPAA. Will prohibit the use of this information for
any civil, criminal, administrative or legislative proceedings—except as otherwise authorized—and contains an antidiscrimination clause ensuring information may not be used in decisions around treatment, employment, housing, access to courts or social services. Patients still have the right to request restrictions on use or disclosure of their SUD treatment records. Requires an update to regulations in no less than a year so covered entities are required to provide notice in plain language on privacy practices to patients.
  ○ The Confidentiality of SUD Patient Records Final Rule is currently at OMB. We provided a summary of the proposed rule. This legislation goes beyond the revised regulation.

Nutrition Programs:
  • Provides $8.8 billion to be used for food purchases and gives schools greater flexibility.
  • Extends Temporary Assistance for Needy Families through Nov. 30, 2020.
  • Provides $15.5 billion for the Supplemental Nutrition Assistance Program to accommodate increased need for food stamps.

Child Care:
  • Provides $3.5 billion for the Child Care Development Block Grant, allowing childcare programs to maintain critical operations.

Package 2: Families First Coronavirus Response Act
H.R. 6201/P.L. 116-127
Signed into law on March 18.

Health Provisions:
  • Temporary 6.2% increase to each state’s Federal Medical Assistance Percentage (FMAP) effective Jan. 1, 2020, through the end of the last quarter of the public health emergency. States may not receive the FMAP increase if they choose to restrict eligibility standards, methodologies or procedures for beneficiaries during the emergency period.
  • Requirement of private health plans to provide coverage for COVID-19 testing and waive cost-sharing and prior authorization requirements for testing and certain related treatment services. Similar cost-sharing waivers also included for Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and TRICARE. Includes a state plan option to provide Medicaid coverage to uninsured patients for the purpose of diagnostic testing and treatment related to COVID-19.
  • Provides $1 billion for the National Disaster Medical System for reimbursement of testing costs for those without insurance.
  • Codifies HHS administrative action to provide temporary liability protections for approved personal respiratory devices under the Public Readiness and Emergency Preparedness (PREP) Act to help increase the supply of respirators.
  • Provides U.S. territories with increased Medicaid funding for all medical services for the next two fiscal years.

School Lunch Provisions:
  • MEALS Act: provides the Secretary of Agriculture the authority to issue waivers for state plans that increase costs to the federal government. Waivers can be applied to both breakfast and lunch.
COVID-19 Child Nutrition Response Act: allows all child and adult care centers to operate as non-congregate, i.e., allows children to take food to go. Allows the Secretary of Agriculture to waive meal pattern requirements in child nutrition programs if there is a disruption to the food supply as a result of the COVID-19 emergency. Provides the Secretary of Agriculture the authority to issue nationwide school meal waivers during the COVID-19 emergency, which will eliminate paperwork for states and help more schools quickly adopt and utilize flexibilities.

SNAP benefits: if a school is closed for five consecutive days during a health emergency when school would otherwise be in session, each household containing one child benefitting from school lunch is eligible to receive assistance. This funding does not have a finite cap.

Package 1: Coronavirus Preparedness and Response Supplemental Appropriations Act

H.R. 6074 / P.L. 116-123
Signed into law March 6, the Coronavirus Preparedness and Response Supplemental Appropriations Act provided $8.3 billion, including funding to support vaccine development, support for state and local governments, and assistance for affected small businesses.

Health Provisions:

- Provides $3.1 billion to the HHS Office of the Assistant Secretary for Preparedness and Response capacity issues—includes $300 million for hospital and health systems’ efforts to prepare and respond, e.g., vaccine purchase and accessibility, necessary medical supplies, and medical surge capacity.
- Waives certain telehealth Medicare requirements so that the recipient does not need to be in a rural community. Requirements that are waived include those related to what qualifies as an originating site and the definition of a qualified provider.
- Provides $2.2 billion to the Centers for Disease Control and Prevention to support federal, state and local public health agencies—includes $300 million for global disease detection and emergency response along with $300 million for the Infectious Diseases Rapid Response Reserve Fund.
- Provides $61 million to the Food and Drug Administration (FDA) for the development and review of vaccines, therapeutics, medical devices and countermeasures, as well as addressing potential supply chain interruptions, and supporting enforcement of counterfeit products.
- Provides $100 million for Community Health Centers. Each center will receive between $50,000 and $320,000 depending on their caseloads and how many patients are uninsured to use for expanding screening and testing, purchasing medical supplies, hiring more staff and expanding telehealth capacity.
- Provides $836 million to the National Institute of Allergy and Infectious Diseases for research and development of vaccines and diagnostic tools.