Federal Response to COVID-19

Yesterday, the Senate passed H.R. 6201, the Families First Coronavirus Response Act. It is now on its way to President Donald Trump to be signed into law. This is the second COVID-19-related supplemental appropriations bill to pass Congress since the beginning of March. There likely will be a third later this month. The first bill focused on capacity and response, the second on both response and economic stimulus, and the third will focus more on economic stimulus with funds set aside for response-related items.

Effects of the President's Emergency Declarations

The president has declared the COVID-19 outbreak a national emergency under both the Stafford Act and the National Emergency Act. This triggers certain waivers to Sec. 1135 of the Social Security Act relevant to hospitals during a public health emergency response. The waivers:

- Ease constraints on the practice of telemedicine (more on this later);
- Waive provisions that limit the number of beds in Critical Access Hospitals to 25 and the length of stay to 96 hours;
- Allow admission to nursing homes without a prior three-day hospital stay; and
- Make it easier for hospitals to hire additional doctors, acquire new office space and move patients within their facilities.

An official outline of what the Sec. 1135 waivers include is available here. For information on best practices related to applying for Sec. 1135 waivers during this crisis, click here.

H.R. 6074, the Coronavirus Preparedness and Response Supplemental Appropriations Act

This bill was signed into law on March 6. It provides $8.3 billion to prevention programs, capacity building, emergency preparedness, humanitarian assistance and vaccine development.

- The Centers for Disease Control and Prevention was given the authority to award $560 million to states to help with their preparation for a large spike in COVID-19 cases.
• Kansas received 90 percent of its $6.6 million award ($5.9 million) on March 16. The funding was made available pursuant to a plan submitted to the CDC by Kansas' designated State Health Officer Dr. Lee Norman, secretary of the Kansas Department of Health and Environment.

• H.R. 6074 also authorized a new Sec. 1135 waiver authority for CMS to allow Medicare funding to cover the cost of certain telemedicine visits. However, it appears that such waiver authority does not currently extend to visits originating at rural health centers and federally qualified health clinics. While this is likely an oversight, it is something that will need to be addressed in the third covid-19 bill.

H.R. 6201, the Families First Coronavirus Response Act
This bill, passed yesterday by the Senate, vastly increases federal spending on COVID-19 response, testing and treatment.

1. It increases each state's federal Medicaid assistant percentage by 6.2 percent; thus, easing pressure on state budgets to cover increased costs related to both care related to COVID-19 infections and the economic impact of people losing employer provided insurance coverage due to job loss.

2. It provides Medicaid coverage at full cost to the federal government for COVID-19-related diagnostic services. This does not include coverage for treatment or preventative care.

3. It requires the federal government to cover the cost of all other COVID-19 diagnostic care. Again, this does not include coverage for treatment or preventative care. This could be confusing for the public who may expect such care to be provided by hospitals free of charge.

4. It provides 10 days (two weeks) of sick leave to people who contract coronavirus or are otherwise required to miss work due to care for another person who is ill or by a quarantine order. In order to qualify, they must work for organizations of less than 500 employees (different rules would apply to large companies). Their rate of pay would be 100 percent up to $511 per day for two weeks and the two-thirds of that rate for the next 10 weeks. Secretary of Labor Eugene Scalia has the authority to exempt workers for hospitals, nursing homes and organizations of 50 or fewer employees from this mandate. The federal government would cover the cost of this program with 100 percent refundable tax credits on companies’ payroll tax payments.

5. It makes a technical correction to H.R. 6074 to allow for Medicare to cover telehealth for patients who have been seen previously by a provider but may not have been a Medicare beneficiary at the time of previous visits.

Third COVID-19 Emergency Supplemental Bill
The third emergency supplemental appropriations bill will include the large chunk of economic stimulus programs. These will likely include direct payments to individuals, payments to businesses, purchases from businesses mobilized by the government for emergency purposes (such as mask and ventilator producers), and payments to health care providers.
The American Hospital Association, American Medical Association and American Nurses Association are requesting $1 billion for health care programming in the bill. They are suggesting that such funds be used for the following purposes:

- To quickly update and train staff on and implement pandemic preparedness plans to respond to COVID-19 in all health care settings.
- Obtain scarce supplies, including personal protective equipment, essential for protecting front-line health care professionals and testing supplies.
- Rapidly ramp up infection control and triage training for health care professionals in all health care settings, especially in light of growing supply chain shortages.
- Provide housing, care and monitoring of patients who do not require hospitalization but must remain isolated to better ensure hospital capacity is preserved for acutely ill patients who require hospitalization.
- Construct or retrofit separate areas to screen and treat large numbers of persons with suspected COVID-19 infections.
- Address the financial impacts of cancellations of elective surgeries and procedures due to shortages of PPE, other medical supplies and the need to keep beds available for COVID-19 patients, as well as patient cancellations due to fear of COVID-19 in health care facilities.
- Plan for, train and implement expanded telemedicine and telehealth capabilities to ensure appropriate care can be provided to individuals in their homes or residential facilities when social distancing measures are used to reduce community spread of COVID-19.
- Increase the numbers of patient care beds to provide surge capacity using temporary structures such as temporary hospitals that are deployed in a pandemic.
- Cover the increased costs associated with higher staffing levels, backfilling staff when necessary (due to unavailable staff or greater need for staff) and special infectious disease units needed to care for patients with suspected or confirmed COVID-19 infection.

The National Rural Health Association has outlined the following priorities for inclusion in the next emergency supplemental bill:

- Expand Sec. 1135 telehealth waivers created by H.R. 6074 to include rural health clinics and federally qualified health centers.
- Prioritize access to no-interest loans to small rural health providers.
- Allow immediate and emergency conversion of a rural prospective payment system hospital to a CAH.
- Suspend the Medicare sequester for at least the duration of the pandemic.
- Update Evaluation and Management office visit codes to cover an office visit using telephonic communications (i.e. Facetime, etc.) when the originating site is the patient’s location (home, nursing facility, etc.).
- Ensure equitable coverage by Medicare, Veteran Administration and Medicaid for COVID-19 reimbursements.
• Ensure federal reimbursement of Medicaid if a state does not allow COVID-19 coverage.
• Ensure licensure barriers are removed and Federal Tort Claims Act protections are temporarily in place.
• Instruct CMS to develop patient surge protections for CAHs and RHCs providing a plan for periodic interim payments to supplement the impact of cash flow during a high-cost, high-volume period of these provider's operations.
• Review ASPR's Strategic National Stockpile plans to ensure rural providers will have access.