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House Releases COVID-19 Stimulus Bill, the HEROES Act

Note: This summary reflects the version of the bill released on Tuesday, May 12.

The Big Picture

On May 12, House Democrats introduced the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (H.R. 6800); the House is expected to vote on the bill on Friday. While Senate Minority Leader Chuck Schumer (D-NY) is supportive of the legislation, Senate Majority Leader Mitch McConnell (R-KY) characterized the bill as a list of "pet priorities" and indicated that the Senate does not feel the urgency to consider an additional round of stimulus right now. Leader McConnell also indicated his intent, when the Senate does consider its own legislation, to focus on liability reform for healthcare providers and businesses, a topic not addressed in the HEROES Act. It will likely be many weeks before the Senate and House are able to reach agreement on another stimulus package, but H.R. 6800 provides an important look at Democratic priorities for the next stimulus package.

The bill includes numerous provisions with a significant price tag (a Congressional Budget Office score is not yet available). Among the most important ones in healthcare are an additional $100 billion for the Provider Relief Fund established under the Coronavirus Aid, Relief, and Economic Security (CARES) Act; $915 billion in state and local relief funds; a time-limited increase in the Medicaid matching rate to support the Medicaid program as enrollment rises; 100% subsidies for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage to help shore up commercial market coverage; special enrollment periods for Medicare and Marketplaces; coverage of COVID-19 treatment with no cost sharing across public and commercial market coverage; and $75 billion for testing, contact tracing, surveillance, containment, and mitigation of COVID-19. Other important provisions include $180 billion in grants for essential workers, targeted funding to help nursing homes respond to the coronavirus, and new flexibilities with respect to Federal Emergency Management Agency (FEMA) funding.

Below is a summary of some of the key healthcare provisions in the HEROES bill:

- Other. *See page 17.*
- Appropriations to Government Agencies. *See page 18.*

Funds for Providers

Among the most significant provisions of the HEROES Act are changes to the $175 billion Provider Relief Fund (Fund) that was established by the CARES Act and provided with an additional infusion of funding by "Stimulus 3.5." The HEROES Act adds more money to the Fund, substantially modifies how not-yet-allocated funding would be distributed to providers, and codifies in legislation requirements for receipt of the funds that, to date, the U.S. Department of Health and Human Services (HHS) has applied via terms and conditions governing the funding.

- **Section 30611. Health Care Provider Relief Fund.** The HEROES Act appropriates an additional $100 billion to the Provider Relief Fund,[1] for HHS to make payments through grants or another mechanism to healthcare providers for expenses and lost revenues due to COVID-19. In addition to adding another $100 billion to the Fund (bringing total funding to $275 billion),[2] the HEROES Act adds considerable new specificity to how HHS must allocate funds among providers; these new requirements would apply to the additional $100 billion in funding *and* the unobligated balance of all amounts appropriated to the Fund by prior stimulus bills. To date, Fund payments have been made at the broad discretion of HHS. In contrast to prior Fund authorizing legislation, the HEROES Act:

    - ***Establishes a standard process through which healthcare providers would submit quarterly applications*** to HHS to access the funds.[3]

    - ***Prescribes a methodology for calculating each provider's payment amount.*** Each provider would be eligible to receive reimbursement for *100% of eligible expenses* (defined as building or constructing temporary structures, construction or leasing of properties, construction or retrofitting of facilities, medical supplies and equipment including personal protective equipment (PPE), tests, increased workforce and training, emergency operation centers, mobile testing units, surge

[1] The bill includes a $100 billion appropriation for the Public Health and Social Services Emergency Fund (see page 87 of the bill), subject to the requirements outlined in Section 30611.

[2] The CARES Act provided $100 billion to the Fund, the majority of which HHS has allocated to date; Stimulus 3.5 provided an additional $75 billion to the Fund. (For more information on allocations to date, see Manatt Health's April 24 newsletter.

[3] To date, providers have automatically received payment for some allocations (e.g., the first $30 billion of the $50 billion General Fund and, for some providers, the second $20 billion as well), have submitted information to HHS to "apply for" and inform distribution of some allocations (e.g., the $12 billion allocation for "hot spot" hospitals), and have submitted claims to receive reimbursement (e.g., the HRSA COVID-19 Uninsured Program). For more information, see Manatt Insights' May 8 summary.

capacity, retention of workforce, and other items defined by HHS) *plus 60% of lost revenues* (for providers with lost revenue that equals or exceeds 10% of their net revenue) *minus any funds that the provider received from COVID-19 stimulus bills during that quarter*.[4] The bill increases Medicaid and Medicare revenue by different amounts to account for lower reimbursement in those programs compared with commercial insurance, which ensures that Medicaid-heavy providers are not disadvantaged.

- ***Bans surprise billing for commercially insured COVID-19 patients and requires acceptance of Provider Relief Fund payments as payment in full for uncompensated care.*** The HEROES Act prohibits providers that receive Provider Relief Fund payments from billing COVID-19 patients[5] enrolled in a group health plan or covered by group or individual health insurance for medically necessary care, including diagnostic testing, in an amount that is more than would apply if the provider were in-network with that provider's plan. Additionally, for uninsured patients, the bill would prohibit providers that receive Provider Relief Fund payments from billing uninsured COVID-19 patients for such care—that is, providers would accept the Fund payments as payment in full for providing medically necessary care, including diagnostic testing, to uninsured COVID-19 patients.

- ***Caps at $10 billion the amount of Provider Relief Fund payments that may be paid to providers for providing uncompensated care***—including, as noted above, any unobligated Provider Relief Fund monies from previously enacted COVID-19 stimulus bills. Following passage of the CARES Act, HHS established a Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program to reimburse providers for testing and treatment of uninsured patients, but it has yet to specify how much of the $175 billion authorized for the Provider Relief Fund to date will be dedicated to the HRSA program. An April 7 Kaiser Family Foundation analysis estimates that total payments will range from $13.9 billion to $41.8 billion.

The HEROES Act also requires various reports related to the Provider Relief Fund, including public reporting by HHS of provider-level payment data and regular recipient reporting, as required by HHS.

[4] Includes all four stimulus bills passed to date: the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), the CARES Act (P.L. 116-123), and Paycheck Protection Program and Health Care Enhancement Act, commonly referred to as Stimulus "3.5." (P.L. 116-136).

[5] The bill clarifies that this applies to patients with confirmed and presumptive cases of COVID-19 and establishes a definition of "presumptive cases." To date, HHS has put forth similar provisions only in Provider Relief Fund FAQs.

- **Section 30631. Reimbursement for Additional Health Services Relating to Coronavirus.** The Families First Coronavirus Response Act (FFCRA) included a $1 billion fund to reimburse providers for claims for COVID-19 testing services provided to uninsured patients. HHS has since allocated that $1 billion in funding to the HRSA COVID-19 Uninsured Program, through which providers may submit claims for testing and treatment of the uninsured. Under current law, HHS would need to separate submitted testing claims from treatment claims and use the $1 billion from the FFCRA only for testing-related claims. (The majority of the funding for the program, as noted above, comes from the Provider Relief Fund, which is more flexible and will be used to pay treatment claims.) Section 30631 amends the FFCRA to allow the funds to be used not only for testing but also for treatment; this likely has little practical effect other than reducing HHS's administrative burden by eliminating the need to separate these claims.

- **Section 30206. Improve the Accelerated and Advance Payment Programs**. Extends the repayment time and lowers interest rates for advances made to Medicare providers under the Centers for Medicare & Medicaid Services (CMS) Accelerated and Advance Payment Programs. Providers would have one year before 25% of the advance is recouped against claims, and at least two years before the entire balance is due in full. The interest rate for the program is lowered from 10.25% to 1%. (For more information about the program and recent CMS updates, see Manatt Insights' April 27 analysis.)

- **Section 30615. Grants for Schools of Medicine in Diverse and Underserved Areas.** In addition to other provisions meant to stabilize the healthcare workforce (e.g., Section 30612, related to a student loan repayment program, and Section 30616, requiring the U.S. Government Accountability Office (GAO) to conduct a study on the public health workforce during the pandemic), the HEROES Act would establish a $1 billion HRSA grant program for schools of medicine in rural and underserved areas and for Minority-Serving Institutions.

- **Section 170102. Pandemic Premium Pay for Essential Workers.** Establishes a new, $180 billion COVID-19 Heroes Fund to which essential work employers would be able to apply for grants to enable them to pay employees pandemic premium pay. Any essential work employer receiving a grant from the Heroes Fund must pay its employees $13 per hour in addition to the employee's regular compensation for work performed from January 27 until 60 days after the last day of the COVID–19 public health emergency. "Essential work" is broadly defined to encompass all aspects of healthcare work (as well as certain other industries) and includes first responders, inpatient and outpatient healthcare work, pharmacy work, medical testing facility work, home and community-based health work, biomedical research, behavioral health work, nursing and family care (including child care), social services work, and public health work, and this provision applies to every employer, regardless of size, that has employees engaged in such work. Essential workers are eligible for up to $10,000 of pandemic premium pay or, for "highly

compensated" essential workers (earning above $200,000), up to $5,000. Additionally, employees are entitled to a lump sum retroactive payment of premium pay for work performed from January 27 until the time the grant is received.

- **Section 30619. Emergency Mental Health and Substance Use Training and Technical Assistance Center.** Provides $20 million in funding for 2020 and 2021 to create a technical assistance (TA) center at the Substance Abuse and Mental Health Services Administration (SAMHSA). The new TA center will support public and nonprofit entities and public health professionals seeking to establish or expand access to mental health and substance use prevention, treatment, and recovery support services during the COVID-19 public health emergency. The center also will develop resources to assist individuals and families experiencing trauma or stress or who have other mental health needs during and after the emergency period.

- **Section 130801. Expansion of Rural Health Care Program (RHCP) of Federal Communications Commission (FCC) in Response to COVID-19.** Expands on funding provided in the CARES Act and authorizes $2 billion for a temporary expansion of the FCC's RHCP to partially subsidize healthcare providers' broadband service. The subsidies will be available to all nonprofit and public hospitals, not just rural ones, and expanded to mobile and temporary healthcare delivery sites. The broadband subsidy rate through the Healthcare Connect Fund Program also would be increased from 65% to 85% for 2019-2021. The program will receive applications on a rolling basis, will make changes to expedite the bidding process, and will require the release of funding for all outstanding requests.

Funds for States and Localities

Responding to calls from state and local officials for additional funds to support their response to COVID-19 and to stabilize economies, the HEROES Act provides an additional $915 billion to states, localities, and tribes, spread across two new state and local relief funding pools. Conditions for the use of these funds appear to be even more flexible than those for the CARES Act's Coronavirus Relief Fund: The new state and local relief funds are directed to be used "to respond to, mitigate, cover costs or replace foregone revenues not projected on January 31, 2020 stemming from the public health emergency, or its negative economic impacts" and are available until expended. Passage of the new funding is expected to be particularly contentious in the Senate because Majority Leader McConnell has expressed strong reluctance to provide federal financial aid to states.

In addition to providing new funds, the HEROES Act also clarifies that states and localities may use the CARES Act Coronavirus Relief Fund for revenue replacement. State and local officials have been requesting this authority, which the Treasury Department has to date rejected. (For more information about the Coronavirus Relief Fund, see the May 8 Manatt Insights summary.)

- **Coronavirus State Fiscal Relief Fund.** The HEROES Act establishes a $540 billion Treasury Department fund to assist state, territorial, and tribal governments with the fiscal impacts from the COVID-19 public health emergency. Most of the funding will be distributed no later than 30 days after the bill's enactment (unless otherwise specified below). The legislation directs the following distributions of the fund:
    - $250 billion in initial payments for states and the District of Columbia, divided as follows:
        - $51 billion divided equally
        - $150 billion allocated by relative population
        - $49 billion allocated by the proportional prevalence of COVID-19 as reported in Centers for Disease Control and Prevention (CDC) data
    - $250 billion in additional payments for states and the District of Columbia no later than May 3, 2021, divided as follows:
        - $51 billion divided equally
        - $199 billion allocated by the proportional "average estimated number of seasonally adjusted unemployed individuals" over a three-month period ending in March 2021
    - $20 billion for U.S. territories (Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), of which $10 billion will be divided equally and $10 billion will be allocated based on relative population.
    - $20 billion to tribal governments as determined by the Secretary of the Treasury in consultation with the Secretary of the Interior and Indian Tribes, based on increased aggregate expenditures of each such tribal government in 2020 compared with 2019.

- **Coronavirus Local Fiscal Relief Fund.** The bill establishes a $375 billion fund for payments to counties, metropolitan cities, and other units of general local government (e.g., towns, villages, parishes) to mitigate the fiscal effects stemming from the COVID-19 public health emergency. Funds will be distributed using a modified version of the Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG) Program's definitions and formulas. Of this funding, $187.5 billion will be distributed to cities and other local governments,[6] and $187.5 billion will be reserved for counties[7] within the states, the District of Columbia, and U.S. territories, divided proportionally based on relative population. Two-thirds of the funding will be

[6] As defined by Section 102 of the Housing and Community Development Act of 1974, "local governments" are "any city, county, town, township, parish, village, or other general purpose political subdivision of a State; Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa, or a general purpose political subdivision thereof."

[7] Provided that no county that is an "urban county" (as defined in Section 102 of the Housing and Community Development Act of 197 (42 U.S.C. § 5302)) shall receive less than the amount the county would otherwise receive if the amount distributed were allocated to metropolitan cities and urban counties.

distributed within 30 days of the bill's passage, with the remainder distributed between April 15 and May 3, 2021.

The Department of the Treasury will provide oversight for the funding allocated under the State and Local Fiscal Relief Funds.

- **Section 10306. CARES Act Coronavirus Relief Fund Repayment to D.C.** Rather than treat the District of Columbia on par with other states, the CARES Act treated D.C. akin to a territory for purposes of Coronavirus Relief Fund distributions, resulting in D.C. receiving significantly less funding than states. This bill appropriates an additional $755 million to provide the District of Columbia with the same minimum amount of funds as provided to other states by the CARES Act.

- **Division S, Title XIII. Coronavirus Relief Fund Amendments.**
  - **Section 191303. Use of Relief Funds.** The bill explicitly expands the allowable uses of the CARES Act's Coronavirus Relief Fund to enable state, local, and tribal governments to use these funds to replace lost, delayed, or decreased revenues stemming from the COVID-19 public health emergency. Governors and mayors have requested this ability to help replace shrinking revenues.

- **Division S, Title XI. Community Development Fund.** Provides an additional $5 billion[8] to the CDBG Program, available until September 30, 2023; changes the CDBG emergency grant period from 121 consecutive months to three consecutive months; waives state match requirements for the funding; requires reporting throughout the public health emergency; and requires adherence to waivers issued by the HUD Secretary.

- **Division S, Title IV. FEMA Federal Assistance.** Allocates $1.3 billion in additional funding to FEMA, of which $100 million shall be for the Emergency Management Performance Grant (EMPG) Program. The grants provide funding to states for emergency preparedness systems. In addition, the bill:
  - Prohibits the use of funds provided in the bill from being used for other purposes.
  - For the Assistance to Firefighters Grant (AFG) and the Staffing for Adequate Fire and Emergency Response (SAFER) Grants Programs, waives cost-sharing requirements for cash-strapped fire departments and waives certain other program requirements in order to help expedite grant awards.

- **Division T. Additional Other Matters**
  - **Section 200005. FEMA Cost Share.** Adjusts the cost sharing from a 75% federal-25% non-federal split to a 100% federal share for FEMA assistance provided

[8] The appropriations are included under Title IX for the Community Development Fund.

under any Stafford Act declaration or any other superseding major declaration for the COVID-19 pandemic. For example, for the FEMA Public Assistance (PA) Grant Program, this change removes the 25% non-federal cost-sharing obligation for eligible applicants (including states, localities, and tribal governments, as well as eligible private nonprofits (which may include applicant providers)).

- **Section 200006. Clarification of Assistance.** Expands FEMA's previous list of eligible expenses for assistance under the March 13 declaration of COVID-19 as a national emergency under the Stafford Act. Eligible expenses are expanded to include, among other things, backfill costs for first responders and other essential employees who are ill or quarantined; increased operating costs for essential government services; costs of providing public guidance and information to the public; costs for establishing virtual services and operating remote test sites; training provided in anticipation of or response to the next emergency declaration; PPE for first responders and other essential employees; medical equipment regardless of whether such equipment is used for emergency or inpatient care; public health costs; costs associated with maintaining alternative care facilities; costs of establishing and operating shelters; costs of procuring and distributing food to individuals affected by the pandemic through networks established by state, local, or tribal governments or other organizations, including restaurants and farms; and funeral benefits. In addition, FEMA is authorized to provide advance assistance (rather than reimbursement for incurred expenses) to an eligible applicant if a failure to do so would prevent the applicant from carrying out such activities.

- **Title VI. CMS: Nursing Strike Teams.** States and nursing facilities across the country are struggling to prevent and mitigate the spread of COVID-19 among residents and staff. Challenges include staffing shortages, clear infection control procedures, and access to sufficient PPE and testing. This provision provides $150 million to support existing and new state efforts to establish and deploy "strike teams" to nursing facilities within 72 hours of residents or staff being diagnosed with or suspected of having COVID-19, to help with clinical care, infection control, and staffing capacity. This money would remain available to states through September 30, 2022.

Testing-Related Funding and Provisions

The HEROES Act includes a number of provisions to build capacity for testing, tracing, surveillance, containment, and mitigation of COVID-19, directing funding to the CDC and states, localities, and tribes and requiring reporting to support both access and monitoring.

- **Sections 30561-30568. COVID-19 National Testing and Contact Tracing Initiative.** The HEROES Act authorizes and appropriates $75 billion for the COVID-19 National Testing

and Contact Tracing Initiative.[9] These sections require HHS, in collaboration with state, local, tribal, and territorial health departments, to establish and implement a national evidence-based system for testing, contact tracing, surveillance, containment, and mitigation of COVID-19; strengthen the existing public health surveillance system; issue guidance and policies to public health departments regarding testing best practices and payment policies; establish awareness campaigns; and conduct related activities. To implement the system, Section 30562 requires the CDC to award grants to state, local, tribal, and territorial health departments in accordance with a formula "that provides a minimum amount of funding to each state, local, tribal and territorial health department that seeks a grant" and allocates additional funding in a way that prioritizes geographies with a high burden of COVID-19 (second and third priorities are also enumerated in the statute). The initiative also authorizes grants to state and tribal workforce agencies to support the recruitment, placement, and training of individuals in COVID-19 contact tracing and related positions.

- **Section 30550. Core Public Health Infrastructure.** Authorizes $6 billion for HHS to establish a core public health infrastructure by awarding grants to state, local, tribal, and territorial health departments; establishing a voluntary public health accreditation program for these departments and public health laboratories; and implementing the accreditation program. The bill does not specify the total funding that should be applied specifically to the state grant program. However, at least 50% of the total amount of funds awarded as grants must be awarded to state health departments, using a formula based on population size and other factors established by the Secretary of HHS within the guardrails of the legislation; and at least 30% must be awarded on a competitive basis to state, local, tribal, or territorial health departments. The funds should be used for core public health infrastructure, including workforce capacity and competency, laboratory systems, testing capacity, health information and analysis, disease surveillance, and other enumerated purposes.

- **Sections 30541-30547. Reporting Requirements Related to Testing.** These sections of the HEROES Act establish various reports to Congress, the Administration, and the public regarding testing, meant to support access to testing and national monitoring of the pandemic. These include requiring:
    - ***The HHS Secretary*** to update the strategic testing plan required by Stimulus 3.5 no later than June 15 and every 30 days thereafter for the duration of the public health emergency, and include additional reporting requirements such as testing capacity in non-healthcare settings. It also would require the HHS Secretary to establish and maintain a public, searchable website that lists all diagnostic and serological tests used in the United States, relevant information about the tests,

[9] The bill includes a $75 billion appropriation for the Public Health and Social Services Emergency Fund (see page 88 of the bill), subject to the requirements described in Sections 30561-30568.

and the number of tests available. The site would also include a list of laboratories approved to perform such testing.
    - ***Test manufacturers*** to submit weekly notices to the HHS Secretary including the number of tests distributed and the entities to which they were distributed.
    - ***States authorizing the development of in-vitro COVID-19 tests*** to submit a weekly report to the HHS Secretary with all laboratories authorized to perform such tests and all tests approved for use in such laboratories.
    - ***States*** receiving funding through the HEROES Act to publish a public, searchable webpage that identifies all diagnostic and serological testing locations in the state and provides the contact information for such sites.
    - ***Labs*** analyzing COVID-19 tests to submit daily reports regarding testing results to the Secretaries of HHS and the Department of Homeland Security (DHS); the agencies must then make the information publicly available.

- **Section 30548. Public Health Data System Transformation, Including Grants to States, Localities, Tribes, and Territories.** Authorizes $450 million for the CDC to conduct activities to expand and improve CDC public health data systems and award grants or cooperative agreements to states, local, tribal, or territorial health departments to expand and modernize their data infrastructure and capabilities, including interoperability of systems.

- **Section 30549. Pilot Program to Improve Laboratory Infrastructure.** Authorizes $1 billion for HHS to award to states and political subdivisions of states to support clinical laboratory improvements related to COVID-19, including to expand and increase testing capacity.

Medicaid and CHIP

The HEROES Act includes a number of provisions that expand on Medicaid and CHIP provisions that were originally enacted in FFCRA, most notably further increasing the Medicaid Federal Medical Assistance Percentages (FMAP) and broadening coverage under the optional uninsured testing group to include vaccines and treatment. The bill includes other provisions to help deliver additional Medicaid funding to states and providers (e.g., additional funding for home and community-based services, additional Medicaid Disproportionate Share Hospital (DSH) funding) and to promote access and continuity of coverage for beneficiaries (e.g., codifying Medicaid's nonemergency medical transportation benefit and extending coverage to inmates of correctional institutions during the 90 days before their release). It is unlikely that all these House provisions will survive in negotiations with the Senate; House leadership ultimately may be most committed to protecting the increased FMAP provisions here, which directly respond to pleas from governors to provide support for their Medicaid programs at a time when state revenues are declining and Medicaid enrollment is growing.

- **Section 30101. COVID-19-Related Temporary Increase of Medicaid FMAP.** Adjusts the FMAP 6.2 percentage point increase provision included in FFCRA to make it a 14 percentage point increase, effective from July 1, 2020, until June 30, 2021. If the public health emergency continues thereafter, the FMAP would return to a 6.2 percentage point increase and remain at that level through the last day of the quarter on which the emergency period ends. The bill does not extend the increased FMAP to additional populations (as some states had requested so that it would apply to the Affordable Care Act (ACA) expansion population), but it does make a technical change to ensure that federal financial participation is available for individuals whose coverage must be maintained as a condition of receiving the increased FMAP. The bill limits the effect of the increase to a 95% FMAP for states.

- **Section 200015. Modification to Maintenance of Effort Requirement for Temporary Increase in Medicaid FMAP.** Modifies the FFCRA maintenance of effort requirement—which prohibits states from receiving the increased FMAP if they implement eligibility standards, methodologies, or procedures that are more restrictive than those in effect as of January 1, 2020—to create an exemption so that New York can implement changes included in its most recently enacted budget without jeopardizing the FMAP. New York's planned changes include more restrictive eligibility requirements for long-term care.

- **Section 30102. Limitation on Additional Secretarial Action with Respect to Medicaid Supplemental Payments Reporting Requirements.** Prohibits HHS from finalizing the Medicaid Fiscal Accountability Regulation (MFAR) during the period of the public health emergency.

- **Section 30103. Additional Support for Medicaid Home and Community-Based Services (HCBS) during the COVID-19 Emergency Period.** Provides a 10 percentage point increase in the FMAP to strengthen and improve states' HCBS programs between July 1, 2020, and June 30, 2021. The increase applies to otherwise increased FMAPs (including for ACA expansion populations receiving HCBS) but may not exceed 95%. To qualify for the FMAP increase, states must apply to HHS and outline focused areas of HCBS improvement (e.g., rate increases, paid sick leave for home health workers, hazard pay, PPE purchases). Funding is intended to supplement—not supplant—the level of funding that states spend on HCBS as of the date of the bill's enactment.

- **Section 30104. Coverage at No Cost Sharing of COVID-19 Vaccine and Treatment.** Includes vaccines and items/services for the prevention and treatment of COVID-19 (including drugs) that are covered as Medicaid and CHIP services during the public health emergency period and directs that these items/services must be offered without cost sharing. For individuals who are infected or presumed to be infected with COVID-19, Medicaid and CHIP coverage during the emergency period includes treatment of conditions that could complicate treatment of COVID-19. Regular Medicaid

"comparability" requirements would not apply, so states can treat such complicating factors without regard to whether such treatments are provided in the same manner to all Medicaid beneficiaries. Such treatments also must be provided without cost sharing.

- **Section 30105. No Cost Sharing for Optional Coverage of COVID-19 Treatment and Vaccines under Medicaid for Uninsured Individuals.** Expands the FFCRA optional COVID-19 Medicaid testing group to include vaccines and treatments for uninsured individuals. During the period that an individual is infected (or presumed to be infected) with COVID-19, coverage would include treatment for conditions that may complicate the treatment of COVID-19. All these services would be matched at the 100% FMAP for states that adopt this optional coverage group. The bill simplifies the definition of "uninsured individual" for purposes of this provision, amending FFCRA to define "uninsured individuals" as those who do not have access to minimum essential coverage. Finally, the bill clarifies that "emergency Medicaid" includes testing, vaccines, or any item or service to treat COVID-19 or any condition that may complicate the treatment of COVID-19, and amends the statutory definition of "emergency medical condition" to include "any indication" that an immigrant eligible for emergency Medicaid may have contracted COVID-19.

- **Section 30106. Extension of Full Federal Medicaid Assistance Percentage to Indian Health Care Providers.** This section clarifies that services received through urban Indian providers from July 1, 2020, through June 30, 2021, are matched at 100% FMAP.

- **Section 30107. Medicaid Coverage for Citizens of Freely Associated States.** Eliminates the five-year bar on Medicaid eligibility for citizens of freely associated states (i.e., Micronesia, Marshall Islands, and Palau).

- **Section 30108. Temporary Increase in Medicaid DSH Allotments.** Provides a 2.5% increase in the Medicaid DSH allotments for FYs 2020-2021, in recognition of the increased Medicaid and uncompensated care burden on hospitals during the public health emergency. Includes a nonbinding "Sense of the Congress" provision suggesting that states should prioritize making DSH payments to hospitals that have a higher proportion of COVID-19 patients relative to other hospitals.

- **Section 30109. Extension of Existing Section 1115 Demonstrations.** Directs the Secretary of HHS to approve—within 45 days of a request and without the need for a federal or state public comment period—states' requests to extend Medicaid and CHIP section 1115 demonstrations that are due to expire on or before February 28, 2021, for a period up to and including December 31, 2021. This provision is intended to ensure continuity of programs and funding during the public health emergency period while streamlining the extension process for states occupied with responding to COVID-19. The bill directs the Secretary of HHS to extend waiver and expenditure authorities and terms and conditions, providing for financial terms and conditions at levels equivalent to the prior demonstration

or program year. As part of their extension requests, states could request new provisions to help address the impact of the pandemic. States would not need to submit a budget neutrality analysis for the extension period, and budget neutrality shall be deemed by HHS to have been met at the conclusion of the extension period.

- **Section 30110. Allowing for Medical Assistance Under Medicaid for Inmates during 30-day Period Preceding Release.** Creates an exception to Medicaid's bar on paying for coverage for "inmates of public institutions" to permit states to provide Medicaid to inmates during the 30 days prior to their release. Also requires a Medicaid and CHIP Payment and Access Commission (MACPAC) report by June 2022 to provide Congress with more information about coverage and access for incarcerated individuals.

- **Section 30111. Medicaid Coverage of Certain Medical Transportation.** Codifies in statute Medicaid's long-standing regulatory requirement to provide nonemergency medical transportation, applying the requirement to both state plan and alternative benefit coverage. Also requires a GAO study examining Medicaid program integrity measures related to coverage of Non-Emergency Medical Transportation (NEMT).

Medicare

The bill's Medicare provisions eliminate cost sharing for Medicare-covered COVID-19 services, provide assistance for skilled nursing and nursing facilities treating COVID-19 patients, and make provisions for increased payments for some COVID-19 treatment services.

- **Sections 30201 and 30204. Eliminating Medicare Cost Sharing for COVID-19 Treatment.** Eliminates any beneficiary cost sharing for Medicare-covered COVID-19 treatment services provided during the public health emergency period. COVID-19 treatment services are defined as any Part A or B covered service that is included in a claim with an ICD-10 code relating to COVID-19. Foregone cost-sharing amounts will be paid by Medicare to providers, which must hold beneficiaries harmless (the bill does not specify how this will affect physicians who do not accept Medicare assignment). Medicare can recover the cost-sharing amounts it has paid, from secondary payers such as employer plans, Medigap, Medicaid, and others that would have been liable for the payment. Medicare Advantage plans must cover these services without cost sharing or, for critical care, any prior authorization, and they cannot take account of this requirement in their bids.

- **Section 30202. Ensure Communications Accessibility for Residents of Skilled Nursing Facilities During the COVID-19 Emergency Period.** Requires skilled nursing facilities to provide reasonable access to a telephone and the internet, and for regulators to issue guidance on making televisitation available.

- **Section 30203. Medicare Hospital Inpatient Prospective Payment System Outlier Payment for COVID-19 Patients.** Increases the Medicare hospital inpatient outlier payment amount for COVID-19-related claims.

- **Section 30205. Coverage Under Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDPs) without Cost Sharing.** Requires Part D plan sponsors to include on their formulary any drugs authorized or indicated for treatment of COVID-19, without cost sharing, prior authorization, or utilization management.

- **Section 30207. Create a New Special Enrollment Period for Medicare.** Creates a new special enrollment period for Medicare Parts A- and B-eligible individuals during the COVID-19 public health emergency.

- **Section 30208. Skilled Nursing Facility Incentive Payments.** Allows skilled nursing facilities to designate themselves (or a portion of their facility) as a COVID-19 treatment center for patients with positive COVID-19 tests, and creates a special payment incentive for these centers.

- **Section 30209. Nursing Home Strike Teams.** Appropriates $500 million for allocation by HHS to the states to stand up strike teams that can deploy to and assist in providing care at skilled nursing and nursing facilities to patients with COVID-19 diagnoses *(see page 8 for more).*

- **Section 30210. Infection Control in Nursing Facilities.** Transfers $110 million from the Part A and B trust funds for Quality Improvement Organizations to provide infection control support for skilled nursing facilities.

- **Section 30211. Nursing Homes Demographic Data Reporting.** Requires collection of and reporting on COVID-19 in nursing homes on Medicare.gov's Nursing Home Compare page.

- **Section 30212. Imputed Rural Floor.** Requires CMS to re-establish a rural floor for the Medicare hospital area wage index for hospitals in all-urban states. This would reverse a policy change that dates back to 2018 and lead to increased Medicare rates of payment to some hospitals in New Jersey, Delaware, and Rhode Island.

Private Insurance

The most significant provision regarding commercial insurance in the bill is providing a 100% subsidy of COBRA coverage. If adopted by the Senate, this provision would likely preserve employer-based coverage for many individuals who lose their job-based coverage as a result of

the COVID-19 pandemic. FFCRA requires insurance plans to cover testing at zero cost sharing, and the bill would require group and individual market plans to also cover COVID-19-related treatment without cost sharing.

- **Section 30301. Special Enrollment Period Through Exchanges; Federal Exchange Outreach and Activities.** Provides for a two-month open enrollment period (starting on the date of the bill's enactment) to allow individuals who are uninsured, for whatever reason, to enroll in coverage. Currently, Americans can enroll in an ACA plan only during the open enrollment period or because of a qualifying life event if they were previously insured. State Marketplaces that separately created a special enrollment period are exempt. The bill also includes $25 million for outreach and enrollment for making consumers aware of ACA-compliant plan options through the federally facilitated Marketplace Healthcare.gov.

- **Section 30302. Ensuring Access to COVID-19 Prevention Care.** Requires the Advisory Committee on Immunization Practices to meet and provide a recommendation no later than 15 days after a COVID-19 vaccine is listed under the Public Health Service Act.

- **Section 30303. Coverage of COVID-19 Related Treatment at No Cost-Sharing.** Requires coverage of items and services related to the treatment of COVID-19 in group and individual market health plans (including grandfathered plans) and waives cost-sharing requirements for COVID-19-related services for consumers diagnosed with COVID-19 during the public health emergency.

- **Section 30304. Requiring Prescription Drug Refill Notifications During Emergencies**. Requires group and individual market health plans to notify consumers about whether their plan will or will not permit advance prescription drug refills during an emergency period.

- **Section 30305. Improvement of Certain Notifications Provided to Qualified Beneficiaries by Group Health Plans in the Case of Qualifying Events.** Employers must give workers losing their employer-sponsored coverage information about all affordable coverage options, including coverage and financial assistance available under the ACA.

- **Section 30306. Earlier Coverage of Testing for COVID-19.** Makes the requirement for free coverage of COVID-19 testing retroactive to the beginning of the COVID-19 public health emergency.

- **Section 30307. Subsidizing COBRA.** Provides full premium subsidies, through January 2021, to allow workers to maintain their employer-sponsored coverage if they are eligible for COBRA due to a layoff or reduction in hours, and for workers who have been furloughed but are still active in their employer-sponsored plan. Individuals who choose COBRA typically pay 102% of the cost of the premium.

Public Health

The legislation does not include any highly significant new authorities or funding related to public health. However, it does include some provisions related to drugs and devices that are worth noting.

- **Section 30511. Medical Supplies Response Coordinator.** The legislation would create the position of Medical Supplies Response Coordinator to lead federal government efforts to ensure the availability of critical supplies including PPE, medical devices, drugs, and vaccines. The position, as the name implies, would primarily work among public and private entities to assess and encourage the availability of critical supplies. However, the legislation would also give the coordinator authority to require industry reporting on production and distribution of supplies and the power to assess financial penalties for compliance failure. The coordinator would also monitor pricing and report any price gouging to the Federal Trade Commission and other government enforcement authorities.

- **Section 100203. Emergency Assistance to Families Through Home Visiting Programs.** This section allows home visiting programs funded under the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to conduct virtual home visits; train home visitors to assist families with emergency preparedness and response; provide emergency supplies to families (such as diapers, formula, non-perishable food, water, soap, and hand sanitizer); and provide prepaid debit cards to families to support emergency needs. It also provides an additional $100 million supplemental appropriation for the program and gives HHS the authority to modify program reporting requirements and extend contracts. These flexibilities expire January 31, 2021.

Prescription Drugs and Vaccines

Notably, despite recent discussion among Democrats of the need to address drug pricing in the context of the pandemic response, the legislation includes no direct price controls. However, it does include some important provisions related to drugs and vaccines.

- **Section 30515. Reporting Requirement for Drug Manufacturers.** Extends foreign establishment drug registration requirements to facilities that manufacture the active pharmaceutical ingredients for drugs, even if such ingredients are later processed before entry into the U.S., and requires drug manufacturers to notify their suppliers of this requirement.

- **Section 30516. Recommendations to Encourage Domestic Manufacturing of Critical Drugs.** Commissions a report from the National Academies of Sciences, Engineering, and Medicine to include recommendations of "strategies to end United States dependence on foreign manufacturing to ensure the United States has a diverse and vital supply chain for critical drugs and devices." "Critical drugs" is broadly defined as those "life-supporting, life-sustaining, or intended for use in the prevention or treatment of a debilitating disease or condition, including any such drug used in emergency medical care or during surgery."

- **Sections 30517 and 30518. Failure to Notify of a Permanent Discontinuance or An Interruption and Failure to Develop Risk Management Plan.** Create criminal penalties for drug companies that fail to provide already required notifications of product discontinuation and fail to develop required risk management plans to deal with product shortages.

- **Section 30519. National Centers of Excellence in Continuous Pharmaceutical Manufacturing.** Incorporates legislation (H.R. 4866) previously introduced by Energy and Commerce Chairman Frank Pallone Jr. (D-NJ) and Rep. Brett Guthrie (R-KY) to give the Food and Drug Administration the authority to designate universities as National Centers of Excellence in Continuous Pharmaceutical Manufacturing. The designation is intended to foster the advance of continuous manufacturing technologies.

- **Section 30520. Vaccine Manufacturing and Administration Capacity.** Authorizes the Biomedical Advanced Research and Development Authority (BARDA) to support the creation of manufacturing capacity for vaccines to prevent COVID-19. Also requires BARDA to make extensive reports to Congress this year on vaccine manufacturing capacity and administration capacity.

Other

COVID-19 Data Reporting Provisions and Funding

- **Section 30571. COVID-19 Reporting Portal.** This section requires HHS to collect data on personal protective equipment, medical supply inventory and capacity at hospitals, hospital systems and long-term care facilities.

- **Sections 30572-30577. Provisions Related to Reporting of Demographic and Health Equity Data.** These sections require several HHS agencies to collect detailed demographic data (including race, age, gender, geography) on those tested for and diagnosed with COVID-19 and report these data regularly to Congress. The sections further require HHS to develop a plan to modernize data collection for health inequities, provide $100 million in grants to states and local governments to implement modernized methods, and provide $25 million to fund health inequities research for American Indian and Alaska Natives.

Behavioral Health

- **Section 30633. Grants to Address Substance Use during COVID-19.** Authorizes SAMHSA to award grants (up to $10 million) to support state, local, tribal, and community organization substance use efforts, including with respect to limiting the spread of infectious disease, and connecting individuals at risk of overdose to education and counseling resources.

- **Section 30634. Grants to Support Increased Behavioral Health Needs Due to COVID-19.** Authorizes SAMHSA to award grants to states, tribes, community-based entities, and primary care and behavioral health providers to increase capacity and support or enhance behavioral health services. Permitted uses to increase capacity and support include upgrades to technology for telehealth and addressing surge capacity for behavioral health needs. Enhancing behavioral health services includes services directed at frontline healthcare workers and outreach to underserved communities, as well as a broad range of services directed toward the public at large.

Appropriations to Government Agencies

- **Department of the Interior.** The bill allocates $945 million for a Capital Improvement Project Fund for hospital and other critical infrastructure and $55 million for technical assistance in U.S. territories.[10]

- **HHS Office of the Secretary.**
    - **Public Health and Social Services Emergency Fund.** The bill allocates $4.575 billion to the Public Health and Social Services Emergency Fund for a wide variety of activities to respond to COVID-19, available until September 30, 2024. This funding includes $4.5 billion to BARDA for expenses to conduct vaccine and therapeutics research ($3.5 billion), for U.S.-based manufacturing facilities ($500 million), and antibacterial research ($500 million), administered by the Assistant Secretary for Preparedness and Response. The remainder is earmarked for program oversight (see below).
    - **Office of the Secretary.** The bill provides $4.02 billion to offset lost lab productivity ($3 billion) and support for additional scientific research ($1.02 billion), transferable to the National Institutes of Health.

- **National Institutes of Health.** This bill provides $500 million to the National Institute of Allergy and Infectious Diseases and $200 million to the National Institute of Mental Health.

- **HRSA.** The bill includes an additional $7.6 billion for primary care under the Health Center Program and for federally qualified health centers for the purchase of equipment

[10] Overseen by the Department of the Interior Office of Insular Affairs.

and supplies and to hire and train personnel for mobile testing. The allocations will remain until September 30, 2025. An additional $10 million goes to the Ryan White HIV/AIDS Program.

- **CDC.** The bill provides an additional $2.13 billion for agency-wide program support for federal, state, and local public health agencies' efforts to fight COVID-19 through September 30, 2024. Of this amount:
    - $1 billion will be dedicated to the Public Health Emergency Preparedness Cooperative Agreements.
    - $1 billion will go to grants for core public health infrastructure for state, local, tribal, or territorial health departments.
    - $130 million will go to public health data surveillance and infrastructure modernization.
    - Additionally, Section 30551 appropriates $1 billion, through the HHS Secretary, to the CDC to expand and improve the core public health infrastructure activities[11] of the agency to address unmet and emerging public health needs. The funding is available until expended.

- **Substance Abuse and Mental Health Services Administration.** The bill includes $3 billion to increase mental health support services related to COVID-19, through September 2021. Designated funding includes financing for the substance abuse prevention and treatment block grant program ($1.5 billion) and the community mental health services block grant program ($1 billion).

- **Oversight Functions.** The bill includes funding for implementation oversight through agency offices of the Inspector General, including the Department of Justice ($3 million); Department of Commerce ($1 million); Department of Homeland Security to oversee the FEMA Program ($3 million); HHS ($75 million); and the Department of the Treasury to oversee the Coronavirus Fiscal Relief Fund ($35 million). The GAO is provided $30 million to conduct audits and investigations related to COVID-19 and stimulus funding.

[11] As defined in Section 30550, core activities include (1) workforce capacity and competency; (2) laboratory systems; (3) testing capacity, including test platforms, mobile testing units, and personnel; (4) health information, health information systems, and health information analysis; (5) disease surveillance; (6) contact tracing; (7) communications; (8) financing; (9) other relevant components of organizational capacity; and (10) other related activities.

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