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Special Bulletin

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Bipartisan Group of Lawmakers Release COVID-19 Relief Legislation

Provisions include funding for health care providers and vaccines, as well as telehealth waivers

A bipartisan group of senators and representatives yesterday released legislative text for both the Emergency Coronavirus Relief Act of 2020, a $748 billion COVID-19 relief package that boosts funding for health care providers, vaccines and testing, and the Bipartisan State and Local Support and Small Business Protections Act that provides $160 billion in state and local aid, as well as certain liability protections for employers, which extend to health care providers in some instances.

The main package would include $35 billion in additional funding for the Provider Relief Fund (PRF) and make changes to the PRF reporting guidelines. Specifically, as urged by the AHA, the package would require the Department of Health and Human Services (HHS) to revert back to its June reporting requirement guidance insofar as it allowed providers to use any reasonable method to calculate lost revenue. In addition, the package would allow health systems to move targeted PRF distributions within their system.

It is not clear what Senate and House leadership will do with the legislation, although it may provide the framework for COVID-19 relief that could be included as part of an omnibus government funding bill that could be taken up as early as this week.

Highlights follow of provisions important to hospitals and health systems.

HIGHLIGHTS OF THE LEGISLATION

Provider Relief Fund (PRF) Provisions. The legislation would allocate an additional $35 billion to the PRF. Similar to current law, these funds may be used to prevent, prepare for, and respond to COVID-19 by reimbursing providers for health care-related expenses or lost revenues attributable to COVID-19. It specifies that at least $7 billion must be used to reimburse rural health care providers and at least $1 billion must be used for tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes. In dispersing funds, this legislation would direct HHS to consider providers that serve Medicaid or at-risk populations, that are at risk of imminent closure, are in bankruptcy, and that have been underrepresented in prior PRF distributions. Providers would have to apply for funds, including by submitting a statement justifying their need.

The legislation would allow providers to calculate lost revenue for PRF reporting requirement purposes using "any reasonable method." It explicitly states that using a method that calculates the difference between budget and actual revenue on a monthly, quarterly or annual basis is permissible. For providers with negative net operating incomes in 2019, it also allows calculating lost income up to a net gain/loss of zero in 2020 and in the first six months of 2021. Providers using one of these methods must attest to their lost revenue calculation within 90 days of receiving a PRF distribution.

In addition, the legislation would allow a parent organization to allocate any or all PRF distributions among subsidiary health care providers of the parent organization. This would include "Targeted Distributions." Parent organizations allocating funds in this manner must notify the HHS Secretary within seven days of the allocation. Subsidiaries must, in turn, note the allocation in any application to HHS for a PRF distribution. In addition, the legislation clarifies that staffing expenses are an eligible expense under the PRF.

Testing, Contact Tracing and Vaccine Administration. This section provides support for vaccine distribution and administration, testing and tracing, and for nursing homes, long-term care facilities, home- and community-based services, and assisted living facilities. It also provides resources for health care workforce recruitment.

Specifically, it provides $6 billion for the Centers for Disease Control and Prevention. Of that amount, $3.42 billion would go to states and other jurisdictions for distribution, administration, and communication about COVID-19 vaccines, which would include tracking systems and data modernization. In addition, $2.58 billion is to be used for vaccine distribution, administration and communication by the Indian Health Service, and the remainder would be available for activities to prevent, prepare for, and respond to COVID-19 domestically or internationally. The bill directs the HHS Secretary to make efforts to identify cross-jurisdictional medical and critical infrastructure workers – workers who reside in one jurisdiction but work in another.

In addition, $7 billion is provided for states, localities, territories and tribes for testing and tracing. This would include $3.5 billion that would go to state, localities and territories; $2.32 billion to hot-spot areas; $827.5 million that can be spent at the HHS Secretary’s discretion; and $350 million to tribes and tribal organizations. Further, the bill allocates $2 billion for nursing homes, long-term care facilities, home- and community-based-care organizations, and assisted living facilities, including $200 million for nursing home strike teams to assist in dealing with the pandemic.

The legislation also allocates $300 million for the Health Workforce recruitment – this includes recruiting for the Nurse Corps and the National Health Service Corps. In addition, $700 million is allocated for research procurements and resource needs, such as personal protective equipment purchases and medical supplies.

Cooperative Efforts to Acquire Tests and Testing Supplies. This section would permit states, territories, and localities to enter into compacts to use funds for cooperative efforts and mutual assistance in acquiring tests and testing supplies. It would direct the HHS Secretary to encourage those forming such compacts to provide

transparency about the terms of the compacts and their acquisitions and to, among other things, set a goal for turnaround of tests of less than 24 hours.

Medicare Telehealth Waivers. Under this section, the bill would grant the HHS Secretary the authority to extend the current public health emergency (PHE) telehealth flexibilities through the end of 2021 should the pandemic end before then. This includes extending both the Coronavirus Aid, Relief, and Economic Security (CARES) Act authority to allow the HHS Secretary to waive or modify requirements for delivering telehealth services and any existing flexibilities the agency implemented through interim final rules during the pandemic. This section also requires the Medicare Payment Advisory Commission (MedPAC) to evaluate and report on the expansion of telehealth services during the PHE, whether any portion of the expanded flexibilities should continue after the PHE, and if so, how Medicare should pay for it, protect program integrity and maintain access to and quality of care.

Additionally, this section would place several requirements on the HHS Secretary related to telehealth, including:

- Publish online the requirements applicable to telehealth and other virtual services before the waivers enacted during the PHE;
- Conduct a study of the impact of telehealth and other virtual services furnished during pandemic on access to care, health outcomes and spending and by practitioner type, patient demographics, and telecommunication modality, among other study requirements;
- Periodically post online during the PHE data on utilization of telehealth and other virtual services and the impact of characteristics described above on utilization; and
- Report on the required study and make recommendations for relevant legislation and administrative action.

Addiction and Mental Health. In addition to allocating $3.15 billion to Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, $1.3 billion to State Opioid Response grants, and $150 million to the Certified Community Behavioral Health Centers (CCBHCs) program, the bill would extend waiver authority for these grants. It also would expand access to medication-assisted therapy (MAT) through the end of 2021 or the end of the PHE, whichever is later, through the following provisions:

- Extend telehealth waivers granted under the PHE through 2021, including the exception to in-person medical evaluations for prescriptions of controlled substances via telehealth technology;
- Add community health aides/practitioners to eligible telehealth practitioners;
- Eliminate separate registration for dispensing Schedule III-V narcotics for MAT (rather than requiring a waiver);
- Provide technical assistance to states to implement training and safety measures for these practitioners; and
- Require a report for the attorney general and HHS by June 2021 on the effects of these provisions on access and diversion.

Finally, the bill would waive the federal fund limitation for the Drug-Free Communities (DFC) support program. Currently, this program requires cost sharing, but the bill would allow the administrator of the grant to provide funds even if the DFC coalition is unable to raise matching funds.

Liability. The accompanying bill, the Bipartisan State and Local Support and Small Business Protections Act, contains an extensive set of findings about the need for protection from frivolous lawsuits related to COVID-19 for health care providers and employers citing a number of risks, including to interstate commerce. The section applicable to health care providers would extend liability protection from civil lawsuits for acts or omissions leading to claims of harm, damage, breach or a tort related to the assessment, diagnosis, prevention and treatment of COVID-19. It also would apply to care provided at facilities at which a patient resides. The term health care provider includes health care administrators and facilities. There are exceptions to these protections for lawsuits brought by federal, state or local governmental authorities and for gross negligence and intentional discrimination. It would not preempt more protective state or local laws. The protection generally would extend from December 2019 and for one-year after enactment or until the end of the PHE. However, a separate provision applicable to COVID-19-related medical liability provides that absent gross negligence no lawsuit may be filed in federal or state court whether before or after the law's enactment.

FURTHER QUESTIONS

If you have questions, please contact AHA at 800-424-4301.