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COVID-19

Omnibus Funding Package with COVID-19 Relief, Health Care Extenders, and Surprise Billing Ban

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The Consolidated Appropriations Act Overview

After a dynamic few weeks of negotiations, President Trump signed into law on December 27, 2020 a nearly 6,000-page legislative package (The Consolidated Appropriations Act, 2021) that includes government appropriations through September 30, 2021; COVID-19 relief funding and targeted policy changes, a subset of which impact health programs; extensions of expiring health programs; a ban on surprise billing; and an amalgam of odds-and-ends health policy provisions.

FY 2021 Appropriations. The bill contains $656.5 billion in non-defense discretionary funding, including $97 billion for the Department of Health and Human Services (HHS)—$2.1 billion above the 2020 enacted level.[1]

COVID-19 Stimulus Package. The $900 billion in COVID-19 stimulus provisions include a handful of key health care priorities, including state and locality funding for COVID-19 vaccine distribution and testing and some policy changes to the Provider Relief Fund. The bill also includes major non-health care provisions, such as Paycheck Protection Program funding and policy changes, stimulus checks, and federal unemployment insurance. However, the COVID-19 stimulus agreement is as notable for what is not included as for what is included. For example, states and stakeholders have been lobbying Congress to replenish the state and locality Coronavirus Relief Fund and to increase the Medicaid enhanced matching rate that applies for the duration of the public health emergency (PHE) and to extend it beyond the PHE. Those provisions to help states weather the economic downturn were not included. In light of these and other health care stakeholder concerns, Democrats—and the incoming Biden-Harris Administration—are likely to revisit COVID-19 stimulus legislation post-inauguration. With Democrats now in control of the presidency and both chambers of Congress, support for another large legislative package may be possible.

[1] For more information about HHS appropriations, see page 27 (Division H) of the House Appropriations Committee summary.

Other Health Care Provisions. The bill also contains several important health care provisions that—until the past few weeks—were not part of the plan for the year-end package. But in mid-December, committees announced they had reached a bicameral, bipartisan agreement to ban surprise billing, resolving a policy issue that had occupied significant time over the past couple of years and providing significant offsets to fund other provisions in the year-end bill. The surprise billing agreement paved the way for Congress to extend expiring health care programs for multiple years and to address odds-and-ends member and committee priorities. For example, the bill addresses long-standing concerns about cost-sharing for colonoscopies in Medicare. However, Congress did not extend Medicaid coverage for postpartum women eligible for Medicaid on the basis of their pregnancy (from 60 days to 12 months), despite recent speculation that leaders were close to reaching a deal that included this policy.

Ban on Surprise Billing. The bill also includes a ban on surprise billing that creates an independent dispute resolution process for determining payment for claims that would otherwise result in surprise bills.

This analysis includes a summary of the following health care provisions:

- COVID-19 relief provisions, including federal and state government funding for vaccines and testing; an extension of the deadline by which state, local, and tribal governments must incur Coronavirus Relief Fund expenses; and additional funding and Provider Relief Fund policy changes.
- Medicaid health care extenders, which in many cases ensure the continuation of otherwise-expiring health care programs for multiple years.
- Delay in Medicaid Disproportionate Share Hospital (DSH) allotment reductions and supplemental payment reporting requirements and other Medicaid supplemental payment provisions that could impact the amount of supplemental payments individual providers receive.
- Other Medicaid provisions, including codifying in statute non-emergency medical transportation requirements.

COVID-19 Relief

In addition to fiscal year (FY) 2021 HHS appropriations,[2] Division M of the bill includes supplemental funding for HHS departments to respond to COVID-19; much of the supplemental funding must be distributed to designated recipients such as states, localities, and tribes/tribal organizations. It also extends the deadline by which states must incur Coronavirus Relief Fund expenses, and modifies some components of HHS guidance regarding use of Provider Relief Fund dollars.

[2] *See* Division H.

Vaccines and Other Countermeasures. The bill allocates various amounts as follows:

- $22.95 billion to the HHS Public Health and Social Services Emergency Fund, for the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, and medical surge capacity. HHS must:
    - Make $19.7 billion available to the Biomedical Advanced Research and Development Authority (BARDA).
    - Allocate no more than $3.25 billion to the Strategic National Stockpile.
- $8.75 billion to the Centers for Disease Control and Prevention (CDC) to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines "to ensure broad-based distribution, access, and vaccine coverage" through September 30, 2024.[3] Of the $8.75 billion, CDC must distribute at least $4.5 billion to states, localities, territories, and tribes. With respect to this $4.5 billion, the bill also specifies that the CDC must:
    - Distribute funding according to the formula that applied to the Public Health Emergency Preparedness (PHEP) cooperative agreement in FY 2020. (This is the same formula that Congress required HHS to use to distribute a portion of testing funding in prior stimulus bills.)[4]
    - Make at least $1 billion available within 21 days of the bill's enactment.
    - Allocate at least $300 million for high-risk and underserved populations, including racial and ethnic minority populations and rural communities.
- $55 million to the Food and Drug Administration (FDA), of which $30.5 million is earmarked for advanced manufacturing of medical products and $9 million is for the development of medical countermeasures and vaccines.

Testing and Tracing. The bill adds $22.4 billion to the HHS Public Health and Social Services Emergency Fund for COVID-19 testing and contact tracing[5]—all of which must be distributed to states, localities, territories, and tribes within 21 days of the bill's enactment. Of the $22.4 billion:

- At least $2.5 billion must be used for high-risk and underserved populations, including racial and ethnic minority populations and rural communities.
- $790 million must be distributed by the Indian Health Service, at its discretion, to its directly operated programs and to tribes and tribal organizations.

[3] The bill enumerates a wide range of eligible uses of the funding, including construction, alteration, and renovation of non-federally owned facilities to improve preparedness and response capabilities at the state and local levels.
[4] HHS has elected to distribute state, locality, and territory testing funds authorized by previous COVID-19 bills via the CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement; the bill allows HHS to continue using this mechanism or an alternate mechanism of its choosing.
[5] The bill enumerates a wide range of eligible uses of funding, including tests for active infection and prior exposure; molecular, antigen, and serological tests; manufacture, procurement, and distribution of tests; testing equipment and supplies; personal protective equipment (PPE) needed to administer tests; and surveillance, containment, and mitigation, among other uses.

The bill requires recipients of the funds (governors or other designees of each jurisdiction) to update their testing and contact tracing plans no later than 60 days following their funding award, and every quarter thereafter until funds are expended. (States submitted their individual testing plans for the duration of 2020 in July.) In turn, within 15 days of receipt of testing plans from fund recipients, HHS must provide to selected congressional committees and make public a summary report of the plans.

Behavioral Health Programs. The bill provides $4.25 billion to the Substance Abuse and Mental Health Services Administration (SAMHSA), including $1.65 billion each for the Substance Abuse and Prevention Treatment Block Grant and the Mental Health Services Block Grant; $600 million for Certified Community Behavioral Health Clinics; and $240 million for emergency grants to states, among other allocations.

Research and Clinical Trials. The bill provides $1.25 billion to the National Institutes of Health (NIH), $1.15 billion of which is specifically allocated to research and clinical trials related to the long-term study of COVID-19.

Coronavirus Relief Fund. Division M, Title X extends the date—from December 30, 2020, to December 31, 2021—by which state, local, and tribal governments must incur Coronavirus Relief Fund expenses. Although many recipients may welcome the extension of the original Coronavirus Aid, Relief, and Economic Security (CARES) Act deadline, this provision may come too late in the year to address the challenge that some states identified in incurring expenses by the end of this year. Nor does the bill address states' pleas for additional funding or for increased flexibility to use the funds to make up for budget shortfalls and revenue losses (the authorizing statute specified that funds may be used only to pay for *new* expenses, those not accounted for in the most recent budget as of March 27, 2020). In October, the National Governors Association indicated that nearly 90 percent of Coronavirus Relief Fund payments had already been allocated. Without additional relief, many states are considering budget-cutting measures, including health care program cuts. Looking to the new year, additional state relief—including increased allocations for the Coronavirus Relief Fund and an increase to and extension of the Medicaid enhanced matching rate that states receive for medical expenditures during the PHE—are likely to be high priorities for the Biden Administration and Democratic lawmakers.

Provider Relief Fund. Division M adds $3 billion to the Provider Relief Fund—bringing total funding to $178 billion—and makes targeted changes to the fund, which was initially created by the CARES Act.

Reporting Guidance. The bill includes a handful of provisions that modify HHS guidance regarding the reporting obligations Provider Relief Fund payment recipients must meet, and thereby modify the ways Provider Relief Fund payments may be used by recipients. The bill maintains the two eligible uses previously established in statute: lost revenues and expenses attributable to COVID-19. It also retains for HHS the discretion to define the reporting

requirements that Provider Relief Fund recipients must meet. However, the bill specifies the following:

- Providers may calculate lost revenues based on the guidance promulgated by HHS in its June 30, 2020 Frequently Asked Questions (FAQs). This provision unwinds guidance HHS issued in October, which defined lost revenues as the year-over-year change in actual revenues from patient care. Providers now may use "any reasonable method" of calculating lost revenues, including comparing year-over-year actual patient care revenues as required by the October guidance[6] or comparing 2020 budgeted revenues to 2020 actual revenues, as previously permitted by the June FAQ. (If providers use the latter approach, the budget must have been "established and approved" prior to March 27, 2020.)
- With respect to Provider Relief Fund payments made to subsidiaries of a parent organization, the parent organization may transfer funds—including Targeted Distribution payments—within the "family." (The Provider Relief Fund is organized into base payments known as "General Distribution" payments made available to all providers and "Targeted Distribution" payments made available to providers based on targeted criteria, such as being a hot-spot hospital; earlier HHS guidance allows for the redistribution of General Distribution, but not Targeted Distribution, payments.)

Although many providers will be pleased that these changes give them greater flexibility for using the funds, some providers will be disappointed that Congress did not also require HHS to reinstate a provision of September-issued reporting guidance that would have allowed providers with negative operating margins from patient care in 2019 to apply Provider Relief Fund dollars to lost revenues up to a net zero gain/loss in 2020. (In other words, the since-rescinded HHS guidance would have allowed providers that were in the "red" in 2019 to apply Provider Relief Fund dollars to lost revenue up to "break even" in 2020.)

Future Distributions. The bill also specifies that HHS must distribute no less than 85 percent of the unallocated balance of the Provider Relief Fund and any funds that HHS recovers from health care providers to eligible health care providers based on their financial losses and changes in expenses that occurred in the third and fourth calendar-year quarters of 2020, or the first quarter of 2021. HHS recently announced that it has begun to distribute approximately $24.5 billion in Provider Relief Fund payments via the Phase 3 General Distribution. A significant portion of Phase 3 payments is based on provider-submitted data related to lost revenues and expenses—but only for the first half of 2020 (January through June). The inclusion of this provision:

- Ensures that providers impacted by COVID-19 later in the year (e.g., providers that experienced a late surge that increased their COVID-19-attributable expenses) will receive a payment acknowledging any losses and expenses they experienced or are experiencing.

[6] This guidance was first promulgated on October 22; the updated November 2 version linked here includes a correction to a drafting error in the October 22 guidance.

- Likely means that significant future allocations of the Provider Relief Fund will come from the Biden Administration. From a practical standpoint, HHS will need to solicit refreshed data from providers (and give providers ample time to submit the data), analyze the data, and announce allocations—a process that is likely to take longer than the remaining month until Inauguration Day.

Medicaid Health Care Extenders

Division CC, Title II includes funding through FY 2023 for the following Medicaid programs.

Money Follows the Person Rebalancing Demonstration. Section 204 extends funding for the Money Follows the Person Rebalancing Demonstration, which helps states rebalance utilization and spending toward home and community-based services (HCBS) rather than institutional care. Additionally, it makes minor program adjustments, including a reduction in the institutional residency period to 60 days (from 90 days), application updates, and new program reports. The bill provides $450 million per year in funding through FY 2023.

Spousal Impoverishment Protections. Section 205 extends through 2023 the "spousal impoverishment protections" that allow states to disregard individuals' spousal income and assets when determining eligibility for Medicaid HCBS.

Community Mental Health Services Demonstration Program. Section 206 extends the community mental health services demonstration program, which provides eight participating states with enhanced funding to improve behavioral health services through Certified Community Behavioral Health Clinics.

Delay in Medicaid DSH Allotment Reductions and Supplemental Payment Reporting Requirements

Division CC, Title II delays Medicaid DSH allotment reductions, modifies the way states must calculate Medicaid shortfall for DSH purposes, and establishes new Medicaid supplemental payment reporting requirements, including policy modifications that would limit the magnitude of supplemental payments to hospitals.

Medicaid DSH Allotment Reductions. Section 201 eliminates Medicaid DSH allotment reductions in FY 2021 and delays the remaining four years of cuts from taking effect until FY 2024.

Figure 1. Change in Medicaid DSH Allotment Reductions

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Previous Reduction Amounts	$4 billion[7]	$8 billion	$8 billion	$8 billion	$8 billion	-	-
Modified Reduction Amounts	-	-	-	$8 billion	$8 billion	$8 billion	$8 billion

Changes to Medicaid Shortfall and Third-Party Payments. Section 203 modifies the maximum amount of Medicaid DSH payments an individual hospital may receive, by redefining what costs are included when calculating hospital-specific DSH limits. States' DSH payments to individual hospitals may not exceed a hospital's uncompensated care costs for uninsured patients and Medicaid patients. The second component—uncompensated care costs for Medicaid patients—is the difference between costs and payments, and is referred to as the Medicaid shortfall.

HHS guidance and rulemaking regarding how hospitals calculate Medicaid shortfall for DSH purposes have been contentious and led to a litany of lawsuits. The issue at hand is how to account for Medicaid enrollees who have another source of coverage, such as Medicare or commercial insurance, when calculating the hospital-specific DSH payment. Although HHS policy has been that states must account for all third-party payments when calculating hospital-specific DSH limits, some hospitals have argued that only Medicaid payments should count against the hospital-specific DSH limit.

In Section 203, Congress adopts an entirely different method for calculating Medicaid shortfall, as recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC). Rather than focus on whether *payments* for individuals with third-party coverage should count in the hospital-specific DSH limit calculation, Section 203 simply omits from the calculation costs for Medicaid-eligible patients with third-party sources of coverage where the third-party source of coverage is the primary payer. As a result, hospitals that treat high volumes of patients with Medicaid and third-party coverage (such as children's hospitals that treat neonates, which commonly are covered by commercial insurance and Medicaid, or hospitals serving large numbers of dual eligibles) will report less Medicaid shortfall. And because many states use hospitals' uncompensated care amounts to distribute DSH payments among hospitals, this change is likely to impact the distribution of Medicaid DSH payments among hospitals in certain states.

[7] Beginning in December 2020.

Supplemental Payment Reporting Requirements. Section 202 imposes new requirements on states to report on any supplemental payments made through their Medicaid programs. By October 1, 2021, HHS must establish a system for states to submit reports on supplemental payment data as a requirement for a State Plan Amendment (SPA) that would provide for a supplemental payment. In their reports, states will be required to explain, among other elements, (1) how supplemental payments are in keeping with the Social Security Act's mandate that Medicaid payments be consistent with "efficiency, economy, quality of care, and access," as well as with the purpose of the supplemental payment; (2) the criteria used to determine which providers qualify for a supplemental payment; (3) the methodology used to distribute the supplemental payments; and (4) the amount of supplemental payments made to each provider.

Importantly, each state's report must provide an assurance that the total payments made to an inpatient hospital provider (but excluding DSH payments) do not exceed the upper payment limit (UPL). There is no hospital-specific cap on supplemental payments subject to the UPL; rather, the UPL is assessed at an aggregate level for defined classes of providers (which is established in statute). Section 202 seems to create a new "hospital-specific" UPL, but does not do so affirmatively. It is unclear whether this was lawmakers' intent and whether Congress and/or the Centers for Medicare & Medicaid Services (CMS) may seek to clarify this provision.

Other Medicaid Provisions

Division CC, Title II includes several additional Medicaid provisions of note.

Medicaid Coverage of Non-Emergency Medical Transportation (NEMT). Section 209 amends the Social Security Act to require that states provide NEMT to Medicaid enrollees (including those enrolled in benchmark and benchmark equivalent coverage) who lack access to regular transportation. Previously, the requirement existed only in regulation, and the Trump Administration had threatened to eliminate it. In, Congress also establishes some guardrails around the new benefit, namely by including NEMT provider requirements and by directing that the Medicaid state plan provide for methods and procedures to prevent unnecessary utilization and to ensure that payments are consistent with efficiency, economy, and quality of care and sufficient to promote access. The bill directs the Government Accountability Office (GAO) to study NEMT services, with a particular focus on preventing and detecting fraud and abuse. The bill requires CMS to report Transformed Medicaid Statistical Information System (T-MSIS) data to Congress along with recommendations regarding coverage of NEMT to medically necessary services; to convene a series of stakeholder meetings to discuss best practices for improving Medicaid program integrity related to NEMT; and to review and update, as necessary, CMS guidance to states about designing and administering NEMT coverage. Finally, the bill authorizes states that utilize NEMT brokerage programs, as permitted under Section 1902(a)(70), to consult stakeholders in establishing their programs.

Medicaid Fraud Control Unit (MFCU) Authority. Section 207 authorizes MFCUs to investigate fraud and abuse in non-institutional settings, enhancing protections for enrollees receiving HCBS.

Medicaid Coverage for Citizens of Freely Associated States. Section 208 eliminates the five-year bar on Medicaid eligibility for citizens of the freely associated states (i.e., Micronesia, Marshall Islands, and Palau) who are legally residing in the United States. This change restores access to Medicaid for this population after a drafting error in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) excluded them from coverage. The provision is effective upon enactment, which will help address a coverage gap that became even more apparent during the COVID-19 pandemic.

Medicaid Coverage of Clinical Trials. Section 210 provides Medicaid coverage for routine items and services provided in connection with participation in a qualifying clinical trial; investigational items and services that are not otherwise covered outside of the clinical trial are not included (but would presumably be paid as part of the trial). The new requirement, which is effective on January 1, 2022, applies to traditional state plan coverage as well as to benchmark coverage.