TEXAS A&M UNIVERSITY
School of Law

"TAMU Law Answers" CARES Act Webinar Series

Webinar 3: Health Care Implications Under the CARES Act

Presented April 13, 2020

Presenters:

- Kip Poe, RN, MSN, JD, Associate General Counsel, Children's Health; Adjunct Professor of Law
- Brendan Maher, Professor of Law
- Maxine Harrington, Adjunct Professor of Law
- Fatma Marouf, Professor of Law and Director of the Immigrant Rights Clinic
- Moderator: Kimberly Stoner, Medical Legal Partnership Law Clinic Attorney

While the panelists are all attorneys, they will be discussing the law generally, and nothing in the webinar should be considered as legal advice. Attendees should consult their own legal advisor to address their own unique circumstances.

TRANSCRIPT:

- Hello, everyone. My name's Kimberly Stoner, and I am the medical legal partner here at Texas A&M University. We are here today on our webinar for the CARES Act, so welcome. Today, we are going to be talking about the CARES Act and the implication it has on the health care system.

Previously we've already done two of these webinars. And the first one we covered individuals, and the next one we covered was small business. We have some more of these programs coming up, including one on April 16 at noon. And that webinar is going to cover how the CARES Act impacts housing, commercial real estate, and bankruptcy.

So please bear in mind everyone that the panel is made up of professors and attorneys. They're all licensed to practice law, however, they will not be giving out legal advice today. Today is just for general information, and nothing in this webinar should be considered legal counsel or advice. If you have your own issues or questions, you need to direct all of your questions to your own legal advisor.

So with that being said, I'd like to introduce our panel. We have Kip Poe. She is a professor at Texas A&M University. She's also a registered nurse, and she is the associate general counsel at Children's Health System of Texas. She has extensive knowledge in health care law. She's going

to be discussing availability of and funding for screening tests, treatment, and vaccines-- who can get tested, where, and when.

We also have Fatma Marouf. She's a professor here at A&M, and she's also the director of the Immigrant Rights Clinic. Her areas of law include immigration law, refugee law, and international human rights. She's going to be discussing the access and care for uninsured, undocumented minorities and native communities, as well as some other things.

We also have Maxine Harrington. She's a professor, and also she's formerly the Associate Dean of Academic Affairs. She has areas of law -- her areas of law include health care, medical malpractice, bioethics, and the law and torts. She's going to be covering the implications of Medicaid and Medicare.

And we also have Brendan Maher. He's a professor, and his areas include complex litigation, procedure, evidence, health care law, insurance, pensions, and corporate governance. And he's going to be discussing funding for medical equipment like ventilators and equipment for hospitals and health care facilities. So with that being said, let me introduce our first speaker, who is Kip Poe. Thank you.

- Thank you, Kimberly. There we go. I had to get my screen shared. Let's see. Just a moment. Let me get back to-- all right.

I think all of you are aware that among the significant reasons for passage of the CARES Act is to support our health care system in responding to the virus and the impact of the virus. When we look at-- and I hope that I am-- I can't see my own screen, but I think that I have this up and sharing, right, so somebody let me know if that's not the case. All right, coverage of diagnostic testing intended to encourage needed testing for anyone that need it-- although there are some fairly significant guidelines from the CDC.

- Your screen is not sharing.

- I'm sorry?

- Your screen is not sharing.

- Well, what are you seeing?

- You.

- Oh, oops-- not my slides. Hold on one second. Let's see if we can.

- Kip, while you're pulling that up, I was just going to let everyone know if you guys have any questions and answers that you would like to post up Q&A, there is a button at the bottom for you to enter all questions. So it looks like Kip is up and running now, so I'll yield it back over.

- All right, do you see me now? OK, all right. Back to testing. We're wanting to encourage testing and mitigating--

- Your slides are not-- you had your slides earlier, but now they're gone.

- Oh my goodness. I am so sorry.

- Y'all tell me when you see them.

- Yes. Yes.

- Everything good?

- Yes.

- Yes.

- Ready to go. OK. Previously before the CARES Act was passed, we had the Families First Coronavirus Response Act, and it required that group health plans and insurance, including Medicare Medicaid covered FDA approved testing and then related physician's office, telehealth, urgent care center, and ER visits that were related to the coronavirus and testing for the coronavirus or treatment for the coronavirus all without any cost sharing, so no deductibles or copayments to patients. No prior authorization required for that. The CARES Act expanded that coverage to include coronavirus or COVID 19 tests that are subject to or requested to the FDA for emergency use authorization and also for state approved tests, which are CLIA-waived laboratory developed tests.

Now I can't move my slides, so let's see. There we go. Pricing of tests, the law does not include or the CARES Act does not include reimbursement amount for the tests. So group health plans and insurers are required to reimburse a testing provider at the negotiated rate if they had one prior to the COVID-19 crisis or emergency.

If there's no negotiated rate, they're free to try to negotiate a rate. If that's not done, then it's at a-- they're to be reimbursed. The providers would be reimbursed for the test at a cash price posted by the provider on the internet. All test providers must post a cash price on the internet, and if they don't do that, they're subject to a $300 penalty per day.

Coverage of preventative services and vaccines, group health plans and insurance are required to cover any qualifying preventative service or vaccine with no cost sharing, so no co-pays or deductibles within 15 days after the date the service is recommended. But to qualify any service-- so any service for the treatment, testing, or vaccine COVID-19 that it must be recommended by the US Preventative Health Care Services Task Force or the CDC Advisory Committee on Immunization Practices.

Funding for the CARES Act-- and I won't go through these numbers. You guys can look at them while they're up on the screen. But a significant amount of money for the health care or to

support our health care delivery system, it does pale somewhat in comparison to some of the other funding. But if you look at the intent is to get the health care delivery system up and running, and relatively speaking when we're talking about businesses closing down and widespread unemployment, it is a lot of funding for the health care system.

So much of the money is going to the health care providers directly for response efforts, so construction of hospitals, temporary hospitals, medical supplies, increased workforce, and so forth. And hospitals have started to get that funding. I think the first of the funding was to go out last week.

So who can get tested, where, and when? Initially our testing was plagued by significant shortages, but the biotech companies started ramping up to come to the rescue. Tests are increasingly available now in every state by the public health departments and hospitals. Requirements for testing sites are state by state.

So each state will determine, whether it has to be a hospital, physician office group. The HHS just within the last couple of days said that pharmacies and pharmacists can provide testing materials. So I think Walgreens is ramping up to provide testing. I saw that just recently being rolled out.

Many sites now have rapid response tests. Previously it was taking anywhere from three to seven days, but now it's generally in under an hour if you are at a place. And most hospitals are now testing with the rapid response test. So people can check their state and local websites for testing locations.

The recommendations on who can be tested have been very fluid, but by and large the CDC has left the determinations to state and local health departments and providers on who they think is important to test. So despite that, we can get some guidance from the CDC on testing. They have the first priority, which is to ensure optimal care for hospitalized patients and to maintain the integrity of the health care system so that more health care providers don't get infected.

So that includes testing for hospitalized patients and symptomatic health care workers. The second group of priority is those who are at highest risk. So that's patients in long-term care facilities, and we've all seen that that's becoming an increasing problem. Those patients are older. They're generally 65 years of age or older, and they're in sometimes tight quarters.

There is limited-- we've tried our best to limit visitation and to test staff for infection and so forth. But it's been a very difficult population to try to protect. So testing is a priority for those individuals-- those with underlying conditions and also for first responders.

Priority number three is to allow tests in the individual or in our surrounding communities that particularly have high community spread, so New York. Now it's becoming Boston, Chicago. I think Michigan's been seen as a hotspot, New Orleans. But it's to test the infrastructure workers, individuals who may not have the above categories and symptoms. But health care workers and first responders are high on the list and then individuals who may have mild symptoms but they

are coming from a community that has widespread community infections. And then non-priority is really individuals that don't have symptoms.

So for my last slide, potential treatment for COVID-19, currently there are no drugs approved by the FDA to prevent or treat the virus. Clinical management really is dependent on infection prevention and control measures and supportive care. So oxygen is a key in treating this disease, and the worse it gets, the most patients-- or the patients who are the sickest are requiring mechanical ventilation.

We do have many, many clinical trials going on. To look at all those, you can go to clinicaltrials.gov. They list all of the trials not just in the US, but across the continents as to what clinical trials are going on.

Some of the most promising that you've probably seen are Remdesivir, which is an IV antiviral drug. Numerous clinical trials on Remdesivir right now. It's also available to some of the very sickest patients through an expanded access program from Gilead Sciences.

You've heard President Trump talk about hydroxychloroquine, which is a drug that's previously been used to treat malaria and certain inflammatory conditions. Numerous clinical trials on that, and some are promising. Some sites say it treats some patients not others. Actemra is another drug that's being looked at and in clinical trials, and they've had some success with that. It's generally a drug to treat rheumatoid arthritis.

And now the many, many facilities are ramping up the ability to provide plasma transfusions from patients who have previously been COVID positive and who have recovered and are now COVID negative. But they have the antibodies to the disease, and that that's being shown to be helpful to patients. So with that until further questions, I'll turn that back over to Kimberly and to our next presenter. Thank you.

- Absolutely. Thank you very much, Kip. Our next presenter is Brendan Maher, and I turn the floor over to him.

- OK, can we see my slide?

- Yes.

- All right, so I am going to talk a little bit about COVID-19 funding with respect to hospitals and health care providers and with respect to equipment that we need to treat the COVID-19 disease. The equipment most people think of when they think of necessary equipment are ventilators, which is a mechanical device to help someone breathe if they can't do it on their own, and personal protective equipment, which are masks and other things to protect them from the virus getting onto their body and then into their system and infecting them. So I'm going to talk about the funding relating to, again, health care providers and equipment we need to [INAUDIBLE].

I thought that I would start by giving a little roadmap of the federal legislation that's out there that speaks to the issues I'm going to talk about. With respect to COVID-19 specifically [INAUDIBLE] enacted three different acts, three different laws. There is a phase one law on March 6, The Coronavirus Preparedness and Response Supplemental Appropriations Act. There was phase two on March 18, the Families First Act.

And then phase three was on March 27. That's what we call the CARES Act. It amended some of the parts of the other two, but it's the big boy. It's the one that set out $2.2 trillion to be spent to address not only the disease but the economic consequences of the pandemic.

And there are two other federal laws that matter for my purposes. One is there is something called the National Strategic Stockpile, which is something that's authorized by federal law that gives the HHS secretary, the Human Health and Services secretary, the ability and obligation to stockpile and deploy things that we would need in the case of a health emergency, like vaccine, ventilators, and masks.

And then lastly, there's something called the Defense Production Act, which was an act that was enacted right after the -- right after World War II in 1950 right before the Korean War that gives the President of the United States tremendous procurement power to respond to national emergencies, whether they're military or health.

So let's talk about funding regarding testing for COVID-19. The COVID 19 relief laws on the books require that most insurance, private group plans, Affordable Care Act exchange plans, insurance like Medicaid must or will cover COVID testing without cost sharing. That's in the Family First Coronavirus Act.

But when the act was being written, some observers noted that not every type of health insurance-- although vast majority overwhelmingly-- but not every type actually were covered by the legislative description of insurance that was put in the Families First Act. So temporary-- some temporary short-term policies, some health care sharing ministry arrangements did not-- were not reached by the Families First Act.

So Families First did to make sure that even people with unusual insurance arrangements would have an opportunity to get a test free of charge is that they said, one, states can expand Medicaid coverage to reach anyone who's an uninsured for the purpose of coronavirus testing. The Trump administration confirmed its understanding that any insurer that doesn't reach for whatever reason for coronavirus testing will be treated as an uninsured, and then lastly Families First made a billion dollars available to reimburse providers who are providing tests to people who are uninsured. So the aim of the law is to make sure that everyone whatever their insurance status can go and get a coronavirus test without having to pay.

The testing is very different than treatment, right. Testing is you figure out whether you have the illness. If you do-- if you don't, great. If you do and you're asymptomatic, OK, you're likely going to fine. If you do and you have symptoms, a significant percentage of those people are going to require real care, serious care. A lot of people are going to be required to be hospitalized, may be put in intensive care.

What is the plan for paying for that? Well, many existing policies would cover the treatment for coronavirus, but there is enormous amounts of people out there who might for whatever reason be uninsured and still need treatment. And so one of the thing the CARES Act does is it provides a $100 billion [INAUDIBLE] fund for the health human services secretary to distribute in his discretion to compensate health care providers for responding to coronavirus costs that they incur in their practice.

And the secretary's discretion, the act on how to spend this money is very, very broad. It's very broad. There are very few limits written into the statute. The Trump administration has said it intends to use some of that $100 billion to reimburse providers who are caring for anyone who is uninsured. So if you have coronavirus and you don't have insurance that covers it but the hospital-- and you're treated, the Trump administration said we're going to reimburse health care facilities that offer that treatment.

Now that's not a small amount. The Kaiser Family Foundation, which is the most respected nonprofit nonpartisan health care organization out there said that it thinks between $14 and $40 billion are going to be spent reimbursing people who are treating the uninsured for coronavirus. Obviously, that's based on stats that are updated every day, but it's a pretty big sum.

The other thing that is of note to people who were paying attention to how to pay for treating COVID-19 is that federal law that Congress enacted does not on its face balance something-- sorry bar something called balance billing. And balance billing is when you go to a doctor and you're covered by insurance, but the doctor's charges are more than insurance pays and so he or she sends you a bill and says you owe me the rest. That could be significant in cases of people who are getting COVID treatment.

But what the HHS secretary has said is that any provider who engages in balance billing is not going to be eligible to get money from $100 billion health fund. It's not exactly clear how it's going to work. It just hasn't yet been documented. But that's the idea. The federal government is going to try and prevent balance billing from destroying people who get treated. We'll see how effective they are at that.

The last thing and I'm running out of time is how are we going to pay and provide for any equipment we need. So the Strategic National Stockpile has been around for 20 years, and it has some number of ventilators and personal protective equipment, masks. It's a secret. The exact number is secret, but it has some amount of those available. And the idea originally behind this Strategic National Stockpile is that the Assistant Secretary for Preparedness and Response who works for the HHS secretary is going to distribute the Strategic National Stockpile items the health countermeasures in accordance with emergency need.

But the problem is that this pandemic rose so quickly in consuming resources, in getting people sick that people were worried there's not enough ventilators and there's not enough PPE to go around. So then the second question is if we don't have enough stuff on the market and in the Strategic National Stockpile, how is it that we get more? Well, there's something out there called the Defense Production Act, which says the idea is that the president can order private

manufacturers to allocate and/or produce for domestic use the items that the nation needs in an emergency, whether it's war or health emergency.

And President Trump invoked the Defense Production Act on March 18 via executive order, and since then he has ordered multiple companies, General Electric, 3M, Vyaire Medical to produce ventilators, N95 masks, hospital beds, and other needed equipment. So the ramping up is occurring. But again, details matter.

We don't yet know, right, whether or not the items are going to be produced fast enough to treat all the people who are sick. Originally, people were very pessimistic, but some things we've seen indicates that, perhaps, flattening the curve has been successful insofar as it's made shortages of equipment be less common than we had feared, although not entirely free of shortages. And I'm two minutes over, so I'll stop there.

- Thank you, Brendan. Up next, we are going to hear from Maxine Harrington. So I yield the floor over to Maxine.

- Good afternoon. How are you today? So the first thing, it's already been said I'm going to be talking about Medicare and Medicaid today. Most of the Medicare changes are to payment providers and some waiver of existing regulations for the emergency period, the pandemic period.

So the first thing's already been mentioned that certainly testing will be covered under both Medicare and Medicaid without any cost sharing. The CARES Act also provides that a vaccine when it's available will be covered under Medicare and Medicaid without cost sharing as well. So the CARES Act attempts to alleviate some of the financial strain on hospitals. As many of you know, many parts of the hospitals are now empty.

Physicians' offices have been closed, so there's been a financial strain from income that normally would have been received during this pandemic period. So one of the first things the Medicare decided to do under the CARES Act is to pay inpatient hospitals, and these are hospitals that are paid under what they call the inpatient prospective payment system. It doesn't cover outpatient facilities or critical care access facilities, but these hospitals will receive an additional 20% from Medicare for patients hospitalized during the emergency period with COVID-19 disease.

Medicare has also expanded their accelerated payment program. This is a program that's currently in existence. If hospitals experience serious financial difficulties due to extraordinary circumstances, Medicare will advance payment amounts against the expected Medicare payments. They're going to be increasing that prepayment amount from 70% to 100%, 125% for critical access hospitals. And critical access hospitals are primarily rural hospitals, so there will be this expansion of trying to get money to hospitals as quickly as possible.

There are-- they've increased the length of time for such payments from three to six months. The recoupment of those payments has also been delayed, and it's also expanded the kinds of hospitals that are eligible for these accelerated payments. So critical access hospitals, which

currently could not get accelerated payments, children's hospitals, and cancer centers are all going to be eligible to get these accelerated or prepayments from Medicare.

The Medicare sequestration-- let me just briefly explain this, but the Medicare sequestration is a current legislation that where Medicare spending is subject to across the board reductions of up to 2%. This has been going on since 2013, and it's scheduled to go on through 2029. The CARES Act suspends this sequestration or the 2% reduction in Medicare payments from May 1st to December 31 of 2020 of this year.

What they're going to do to make up for the budget shortfall, they'll just extend the sequestration now through 2030. This suspension of the 2% reduction in Medicare applies to all Medicare providers, both inpatient and outpatient facilities and to physicians who accept Medicare. There are also provisions for other reductions that were to take place under Medicare. There was a durable medical equipment payment reduction, a clinical laboratory test payment reduction that was scheduled to go into effect. These have also been delayed and will not go into effect during the pandemic period.

There have been a number of regulatory requirements under Medicare that have been eased in order to improve access to care. I'm not going to go through all of them, but I will hit some examples of those waivers in easing of regulatory requirements. One of them is that inpatient rehab facilities that are currently required to provide at least three hours of intensive therapy or 15 hours a week, now they can provide less therapy under the-- at least during the pandemic period.

Payment for home health services used to have to be certified solely by a physician. The CARES Act allows an advanced nurse practitioners and physician assistants to certify that home health services are necessary. The regulation Medicare sometimes won't allow people to fill drugs for more than 30 days. Under the emergency period, Medicare patients will be allowed to get prescriptions filled or refilled for up to a 90 day period from their pharmacy.

Telehealth, there are a lot of waiver requirements in Medicare to increase the use of telehealth during this emergency period for obvious reasons. People don't want to have person-to-person or face-to-face contact with providers. So first of all, probably the most important waiver is that the patient receiving services under Medicare, Medicaid, or CHIP which is the Children's Health Insurance Program, they waved the requirement that you have to have a prior relationship with a provider during the previous three years. So with that, a lot of new patients will be able to get telehealth under any of these three programs.

Previously federally qualified health centers and rural health clinics were not considered to be distant sites for telehealth. That's changed under the CARES Act. They are now going to be allowed to provide telehealth services and to be reimbursed, most importantly, by Medicare for those services.

There's also been a waiver of face-to-face visits for home dialysis patients. So patients who have end stage renal disease under Medicare are now can get monthly telehealth assessments instead of face-to-face assessments. Hospice physicians or nurse practitioners may now conduct

telehealth meetings with patients to determine their continuing eligibility for hospice, and there is one part of the CARES Act that encourages telehealth services for home health services. Not quite sure how that's going to work, but the Health and Human Services is supposed to issue guidelines for home health services, telehealth.

Medicaid, so this has already been mentioned by Professor Maher. But there is an option for states to extend Medicaid eligibility to the uninsured population for COVID testing. The government will be paying 100% of the cost if the states want to do this, and Professor Maher talked about who are the uninsured. I just want to point out that uninsured adults under the CARES act also includes anyone below 138% of the federal poverty level in states that did not expand Medicaid.

So under the Affordable Care Act, I want to say 36 states have now expanded Medicaid for adults who have incomes below 138% of the federal poverty level. Texas has not opted to extend and expand Medicaid, and to my knowledge today Texas has not opted have taken up on this option for states to extend Medicare testing for the uninsured for COVID-19. So the uninsured apparently in Texas at least don't have an option at this point in time to get free testing through Medicaid eligibility. They do through other- through that $1 billion fund under the national health disaster fund.

Now another provision is that the unemployment compensation add-on that was provided by the federal government-- I think it's $600 a week for unemployment compensation-- the act provides that that unemployment compensation will not count as income for an individual who applies for Medicaid or CHIP. I think state unemployment benefits will still count for Medicaid eligibility, but at least the federal add-on under the CARES Act will not. Under Medicaid, Medicaid is currently funded-- original Medicaid, I should say, is currently funded by a matching federal funding. So the minimum that states get is 50% match. So if you have Medicaid expenses and Medicaid billings, the federal government will match that a minimum of 50%.

So some states now will receive an additional 6.2 federal match during the emergency period. I believe Texas' match currently is 61.8%. So the federal government picks up 61.8% of the Medicare expenses in Texas, and then with this add on it will be about 67% that the federal government will pick up. Excuse me.

Note that this doesn't apply to Medicaid expansion states. For states that the 34 states that did expand Medicaid under the Affordable Care Act, they already have a federal match of 90% currently. So this additional match only applies to states that didn't expand Medicaid and to the original Medicaid population and not the expansion population.

Medicaid also there is a disproportionate share hospital payments that are given to the states. I believe Texas' allotment is almost close to a billion dollars at this point, one of the highest in the country with California and New York and probably Florida, I think. There had been scheduled delays.

The Affordable Care Act mandated cuts in the disproportionate share hospital payments, and these are hospitals that disproportionately serve low-income patients, Medicaid patients, and so

they have a great deal of uncompensated care. So these hospitals were scheduled to receive cuts in their disproportionate share payments under the Affordable Care Act. And the reason for that was because the Affordable Care Act contemplated that almost everybody would be eligible for Medicaid in the states, and they would expand their Medicaid.

Of course, that didn't quite work out. Again, there's 14 states that didn't do that. But there have been delays in these cuts since the Affordable Care Act was enacted. The last delay said that the cuts would begin on May 20 of 2020 or May of 2020, but now that's been delayed again until December 1st of 2020, and the $4 billion in cuts won't start till December 1st.

I suspect there may be another delay after that. We'll see how long this pandemic period lasts. And then over the next years, the cuts will be delayed from $8 billion a year to $4 billion a year rising to $8 billion a year through 2025. So that's all I have for Medicare and Medicaid, and I'll be happy to answer questions when we're all through with our presentations.

- Thank you Professor Harrington. Up next, we have Professor Fatma Marouf, and she is going to be talking to us about her presentation. So I yield the floor-- sorry, Fatma. Go ahead.

- All right, I'm just sharing my slides. So I'm going to be talking about access to care for specific groups, namely the uninsured, immigrants, veterans, minorities, and incarcerated individuals. Now I know a couple of speakers have touched on the uninsured already, but I will just highlight some key points.

So there's about 28 million Americans who are uninsured, and that rate is probably getting higher every day as more people are losing their jobs. So in the last few weeks alone, 3.5 million people lost employer sponsored insurance, and some projections show that up to 11 million people could become uninsured as a result of the pandemic.

So the CARES Act builds on the Families First Act, as was pointed out, and that act allowed states to use their Medicaid programs to provide free testing for uninsured persons. And that was limited to testing. And so what the CARES Act does is it says some portion of that $100 billion to relieve health care providers will go to the costs of care for the uninsured.

And as I think Professor Maher pointed out, providers will be prohibited from balance billing. And what-- their reimbursement will be limited to Medicare rates, which is about half of what private insurers pay. There is a broader definition of the uninsured that includes not only people with no insurance but also anyone enrolled in a plan that doesn't meet the minimum essential coverage as defined by the ACA and people who fall in the Medicaid coverage gap, so low-income adults in states that have not expanded their Medicaid programs.

There is a lot we don't know yet. We don't know how much of this $100 billion for providers is going to be used to pay for the care of the uninsured, and we don't know exactly what will be covered. So will it be limited to hospital care? Will it include, for example, physician services billed separately from hospital services? What about care outside of hospitals, including follow up care?

And for example, we don't know for people who ultimately test negative what part of their care will be covered. And I think as Professor Maher also pointed out, some of these estimates are showing that treating the uninsured alone could cost up to $40 some billion, and that's already 40% of the total. So it's important to think about other options for covering the uninsured, and some ideas that have been noted is having the federal government designate a special enrollment period for the ACA, which many states have already done but the federal government has not. And that exchange serves 38 states, expanding Medicaid, using the National Disaster Medical System, or Congress could create a new special fund just for the uninsured.

OK, turning to immigrants, the CARES Act does not provide any new insurance options for immigrants. So under current laws, there are certain groups of immigrants with status who are designated to receive federal Medicaid or who couldn't get insurance through the ACA. And those groups, which are defined as people who are lawfully present-- a term of art used by the ACA-- still excludes many people. So undocumented people are excluded from both federal Medicaid and the ACA as are other large groups, such as, for example, DACA recipients, which are the "dreamers," the people with Deferred Action for Childhood Arrivals.

So in addition, some states will extend coverage to additional groups of immigrants. And if you're interested in the state specific benefits, the National Immigration Law Center has a terrific chart that's available at this link https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states.pdf . For undocumented immigrants and others with no coverage or, yeah, who don't qualify for any coverage, the only options really are emergency Medicaid if they are low income or non-emergency care at community health centers or safety-net hospitals.

And some states have defined already COVID-related testing and treatment as emergency service, so that would be covered by emergency Medicaid. But the applicants would still have to meet the state's other Medicaid eligibility requirements. The CARES Act also specifically designates $1.3 billion funding this year for community health centers and an additional $668 million for part of next year.

Many immigrants are worried that they will be labeled "a public charge," which is a term to describe an immigrant who cannot support themselves in the US and is bar certain visas and becoming a permanent resident, and because of those fears there's a concern that people are not going to access the care they need. Now US Citizenship and Immigration Services or USCIS has announced that testing and treatment related to COVID will not be used against immigrants as part of a public charge test, but of course, that does not necessarily quell all the fears.

I'm going to just say a quick word on veterans. There is $17.2 billion allocated directly to the Veterans Health Administration, and that will go mostly towards recruiting medical personnel, who will focus exclusively on COVID care, also to buy equipment, ventilators, PPE, pharmaceuticals, and provide overtime pay. And as Professor Harrington talked about some of the telehealth expansion, this is also true for veterans. Some of this money will go towards increasing the telehealth resources for veterans, especially those who are homeless or need mental health care.

I do want to say a few words about racial and ethnic minorities, because they have been disproportionately affected. For example, African-Americans are being hospitalized and dying at disproportionately high rates. As an example, in Michigan African-Americans make up 14% of the population but 41% of COVID-19 deaths. And there are many possible reasons for this, including higher rates of underlying medical conditions, working in essential service jobs where they can't telecommute, being less likely to have health insurance, and some studies have shown that doctors are actually less likely to refer minority patients for testing despite having COVID symptoms.

So with respect to racial and ethnic minorities, gathering data and releasing it is really important. This will help us determine whether we need to increase testing among certain communities, which is important to figure out what are the best medical interventions. For Native Americans specifically, that CARES Act allocates $500 million to Indian Affairs, which is an agency within the Department of Interior, and $8 billion to tribal governments. And that is supposed to be distributed by April 26.

So tribal leaders are currently being consulted about how to come up with a method for allocating that $8 billion. And this is a group that's very much at risk. For example, only 3% of tribes have actually received any diagnostic kits.

The last group I want to touch on is incarcerated populations. As you can imagine, incarcerated populations are very much at risk because of the impossibility of social distancing. And the Bureau of Prisons, so this is over federal prisoners have been provided $100 million to respond to the pandemic with resources, such as PPE, medical equipment, overtime pay, and money to clean facilities.

They've also been permitted greater flexibility with home confinement, so expanding the maximum amount of time that a prisoner can be sentenced to home confinement instead of being incarcerated. Interesting with respect to immigration detainees, which are the largest detained population in the US, there are no provisions made in the CARES Act. So this is a major issue now facing immigrants in detention, and that's about 35,000 people a day. So I will conclude there. Thank you.

- Thank you, professor. I'd like to remind everybody that if you have any questions, please go ahead and submit them. We'll try to get to all the questions that are being asked as we are speaking. But for now, Kip, I have a question for you. Is there a particular website where all the prices for testing are posted, or should it be on a website for the provider or do you have any guidance on that-- or anybody if anybody has any guidance on that?

- It's generally been state by state. So if you-- like, whatever county that you're a resident in if you'll just pull up your county, I mean, you can literally Google your county. So like Tarrant County, Dallas County, whoever and if you just put in coronavirus, it will bring up your county's website. And most counties and at least the larger counties now have websites, and they will have testing centers listed on there.

If they don't, you can call the local public health department and they should have listings of all the testing sites that you can go to. And I think I mentioned earlier, the Health and Human Services just authorized pharmacies to provide testing. So I think people are going to start seeing more and more that they can go to a local pharmacy and get the testing. There is also a move for self-testing to be available, and I don't know how they're planning to distribute those test kits but that may be an option that we see in the next few weeks.

- Thank you. Maxine, I have a question for you, professor. Can non-Medicare patients receive 90 days of medication under the current circumstances? Hold on. I think-- I think you're on mute.

- I'm sorry. That would depend upon the plan, the private insurance plan. I think there's a number of private insurance plans that already allow people to get 90 day supplies of medications. Medicare has stricter regulations on that, so they're waiving for this pandemic period.

But I would just contact the private insurance plan to see whether they will allow 90 day supplies. Generally, the private insurance companies often follow Medicare regulations, so I would think that they would. But I don't know how each individual insurance company is handling this.

- Thank you. And then I have another question, and I think this-- Brendan or Maxine, either one of you jump in here, but for the funding available to small medical facilities and designated as a grant, can the funding only cover COVID-19 related treatment or can it be applied to cover other expenses?

- Let me. Brendan-- I think you're muted, but--

- I didn't hear the question.

- Oh, I'm sorry. Let me repeat it.

- From the funding available to small medical facilities and designated as a grant, can that funding only cover COVID-19 related treatment?

- The funding from where? Any funding that's coming from-- that's designated at grant money. I think the question is--

- So the $100 bill that was given to create the fund that's in the discretion of the HHS secretary, its language is extremely broad. It says, though, that it should be used for things that are attributable to coronavirus. But nobody knows what “attributable to coronavirus” means, right. We know in law that attribution or causation can be very narrow or very broad depending on how we interpret it. So it's not yet clear what the secretary is going choose as to consider costs attributable to the coronavirus.

- Yeah, let me add something here too. I think that just very fairly recently they distributed about $30 billion of this fund to hospitals, and the first $30 billion is just simply going to hospitals based upon their Medicare billings. So it doesn't seem to be directly related to the coronavirus. In

fact, there have been some criticism about this first release of funds, because it doesn't seem to be geared toward areas or hospitals that have had a particular problem with the coronavirus.

- There are lots of unanswered questions. As some of more of the information comes out-- and this is just for the whole panel-- is there areas where people really should be checking like websites and places where they can go for additional information? I guess we're all shy. Have you guys--

- I would say that the CDC has a very good website. They update it frequently. I mean, about almost weekly the CDC updates their website. I know the CDC's had some criticism over the early start, but I think they are now moving forward pretty rapidly with this pandemic. So I've actually found some very good formation on the CDC's website with regard to the health care response of it.

- You can also check--

- Kaiser Family Foundation, I think, is a great source for-- the Kaiser Family Foundation is a great source for people who want to have sophisticated analysis expressed in plain English about what's happening with respect to coronavirus initiatives, like, what are they supposed to accomplish, what are objections people have raised, what are things that are unresolved. It's pretty useful, and it's coming from people who know what they're talking about.

- You can also probably check the state resources in the state you're in. For example, Texas has been pretty good about information relating to what they're doing as a result of the coronavirus pandemic. For example, with Medicaid, they are automatically renewing everybody on Medicaid without the need to file any more forms or anything of that sort. You don't need to come in for interviews, physical interviews, if you're applying for Medicaid eligibility. So you can check on the state resources, the websites as well to find out the current state requirements as they implement this-- the moneys and the regulations that they're involved in.

- It looks like we've got a question in here. Is there any funding allocated to staff people for doing contact tracing once we get into containment? Anyone have any information on that? It's probably still in the unknown. We have an opinion question in here. Terry wants to know what everyone thinks of the government's get back to work plan. Anyone want to field that one?

- I'm sorry. My connection is terrible for the last two questions. I apologize.

- Oh, you're fine. Can you-- the first question was is there any funding allocated to staff people for doing contact tracing once we get into containment?

- Well, the CARES Act does provide-- and again, I only heard part of the question, but I'll just professor style say the things that I think are responsive. The CARES Act does provide for a bunch of money to be used for the federal government to reimburse government entities, states, municipal-- local [INAUDIBLE], territories, like Guam, what have you, for actions they take in response to coronavirus. So it's not clear what-- if I get the money.

So it's not clear the metric by which the money is going to be given to the government units that are responding. But it seems to me that there's freedom and flexibility there that in some ways is a virtue but in other ways is a vise, right. It's like we want it to be used for things that might be very useful in opening up the economy like contact tracing, but that means also we have to be thoughtful about what money is not being used-- what the money is not being used for. So the answer to the question is, I think, there's nothing-- the answer to the question is, I think, there is money for states and government units that are trying to [INAUDIBLE] measures to help stop the virus from continuing to explode.

- I have an additional question. Is there are additional administrative funding available for state divisions in Medicaid as attributable to C-19 or specific other funding under the CARES act?

- Yeah, the answer to that there is funding again-- not specific funding attributable to COVID-19, the testing moneys. I mean, obviously anybody who's covered under Medicaid can get testing for free, but it doesn't apply to treatment. This will have to come from the general fund of $100 billion that they've allocated to the hospitals to try to get reimbursement for treating people for care.

Now Medicaid will, of course, pay for treatment as well to the extent that somebody is diagnosed and is in a hospital. So I'm not sure I understand the question, but there's nothing specifically relevant in terms of Medicaid funding other than the increased federal match that goes to Medicaid of 6.2% per year.

- Well, thank you. [INAUDIBLE]. OK, it looks like we are out of questions. So at this point, thank you professors for taking the time and speaking to everybody and then providing insight in this very complicated and still growing topic.

For our audience, I would just like to remind you that we have another one of these webinars. It is on the 16th, and it's at noon. And that's going to cover housing and commercial real estate, as well as bankruptcy.

So we look forward to seeing everybody there. So thank you for the time. And professors, we really appreciate you taking time out of your day to put on this presentation.

- Thank you.

- Thank you.

- Thank you.

While the panelists are all attorneys, they will be discussing the law generally, and nothing in the webinar should be considered as legal advice. Attendees should consult their own legal advisor to address their own unique circumstances.

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