The COVID-19 pandemic has created unprecedented challenges for healthcare providers and health insurers. The following is a selection of federal and state actions as well as news and analysis articles from the Health Policy Tracking Service as published in its June 1 bi-weekly Snapshots. The selection includes Regulatory Intelligence and Reuters news coverage. More COVID-19 news and information can be found via the TRRI platform's search facility.

Additional COVID-19 resources are also available on the Thomson Reuters COVID-19 Resource Center. For a regularly updated list of U.S. state updates on insurance-sector regulatory changes related to the COVID-19 epidemic, please click on this link: http://go-ri.tr.com/fuaD4N. For an updated summary of federal legislation and regulations related to the pandemic, please click on this link to the Skopos Labs Coronavirus Policy Tracker: https://coronavirus.skoposlabs.com.

You can create your own custom My Updates through the Create a Custom My Updates link on the Regulatory Intelligence homepage. Select your geography and/or content types you would like resources from and include the following keyword search: covid! or corona-virus.

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COVID-19 COVERAGE

COVID-19 LEGISLATIVE AND REGULATORY ACTIONS

FEDERAL ACTIONS

Federal
2019 CONG US HR 7048, introduced to the House on May 28, would require the establishment of requirements for skilled nursing facilities, nursing facilities, and assisted living facilities to manage the outbreak of COVID-19, and for other purposes.

STATE ACTIONS

California
- 2019 CA S.B. 932 (NS), amended/substituted May 19, relating to COVID-19 data collection for communicable diseases.
- 2019 CA A.B. 2644 (NS), amended/substituted May 20, would, in the event of a declared emergency related to a communicable disease, require a skilled nursing facility to report each suspected disease-related death to the county coroner within 24 hours of that death, and the county coroner to report that death to the State Registrar within 24 hours of receipt of that notification. The bill would also require the State Department of Public Health to report certain information related to those deaths on its internet website on a weekly basis.

Colorado
- 2020 CO H.B. 1385 (NS), introduced May 26, 2020, in connection with the increased money received due to the federal "Families First Coronavirus Response Act," making and reducing appropriations for nursing facilities and other medical assistance programs.
- The Department of Health Care Policy and Financing intends to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to change the class 1 nursing facility supplemental payment for cognitive performance scale by permitting a one-time revision for State Fiscal Year 2020-2021 to pull Minimum Data Set (MDS) data that is most recent and unaffected by the Coronavirus Disease 2019

Illinois
- **2019 IL H.R. 852** (NS), introduced May 21, urges the Illinois Department of Public Health, the Illinois Department of Human Services, and all other relevant agencies and boards to examine the rise in opioid overdoses due to COVID-19. Urges the State of Illinois to increase access to naloxone.
- **2019 IL S.R. 1184** (NS), introduced May 21, urges the Illinois Department of Public Health, the Illinois Department of Human Services, and all other relevant agencies and boards to examine the rise in opioid overdoses due to COVID-19. Urges the State of Illinois to increase access to naloxone.
- **2019 IL S.B. 3989** (NS), introduced May 19, provides that, notwithstanding any other provision of law, any individual, business, or unit of local government shall not be liable for any civil damages for any acts or omissions that result in the transmission of COVID-19, other than damages occasioned by willful and wanton misconduct by the individual, business, or unit of local government. Provides that, with the exception of willful and wanton misconduct, a health care provider shall be immune from civil liability for any injury or death relating to the diagnosis, transmission, or treatment of COVID-19 alleged to have been caused by any act or omission by the health care provider, which injury or death occurred at a time when health care provider was providing health care services consistent with current guidance issued by the Department of Public Health. Provides that the Act applies to any cause of action arising on or after January 1, 2020. Effective immediately.
- **2019 IL H.B. 5781** (NS), introduced May 19, amends the Illinois Emergency Management Agency Act. Provides that no occupational or professional license issued by any State agency to a business or person may be revoked or suspended based upon a failure to comply with an executive order related to the COVID-19 Pandemic, unless a court order has been obtained to allow such license revocation or suspension. Provides that no State agency or employee of that State agency may enter on to the premises of a business or person for the purpose of effectuating the revocation or suspension of an occupational or professional license based upon a failure to comply with an executive order related to the COVID-19 Pandemic, unless a court order has been obtained to allow the enforcing State agency to enter on to the premises for such purpose and notice has been provided to the relevant State legislators of the district in which the business or person resides. Effective immediately.
- **2019 IL H.B. 5784** (NS), introduced May 20, amends the University of Illinois Hospital Act and the Hospital Licensing Act. Requires hospitals organized or licensed under the Acts to report to the Department of Public Health the demographic data of individuals who have symptoms of COVID-19 and are released from, not admitted to, the hospital.
  The provisions of the Assisted Living and Shared Housing Act [210 ILCS 9/30(a)] and [210 ILCS 9/110(a)], requiring that IDPH conduct an annual on-site review for each establishment covered by the Act and an annual unannounced on-site visit at each assisted living and shared housing establishment, are hereby suspended. See 2020 IL REG TEXT 554841 (NS).

Louisiana
- **2020 LA H.R. 38** (NS), engrossed May 21, urges and requests the La. Department of Health to study and develop a remote patient monitoring initiative in the state Medicaid program as an important tool to monitor patient health during the COVID-19 public health emergency.
- **2020 LA H.R. 44** (NS), introduced May 18, directs the governor to ensure that individual liberty and rights are protected as the state administers contact tracing.
• **2020 LA H.R. 45** (NS), engrossed May 21, directs state agencies and licensing boards to suspend the imposition of sanctions against licensees and permittees for a violation of COVID-19 executive orders.

• **2020 LA H.R. 61** (NS), introduced May 29, urges and requests the La. Department of Health to study and report on the matter of racial disparities in COVID-19 death rates in this state.

• **2020 LA H.C.R. 73** (NS), engrossed May 18, requests an update from the Louisiana Department of Health and the division of administration on efforts to establish an application or system to track the incidence and spread of COVID-19.

• **2020 LA H.C.R. 74** (NS), engrossed May 18, to request that CARES Act funding be made available to the state for testing and be distributed to healthcare systems.

• **2020 LA H.C.R. 93** (NS), engrossed May 22, directs the governor to ensure that individual liberty and rights are protected as the state administers contact tracing.

• **2020 LA H.B. 589** (NS), enrolled May 27, provides for Medicaid policies and procedures concerning telehealth services.

• **2020 LA H.B. 826** (NS), engrossed May 22, relative to the limitation of liability; to provide for the limitation of liability during the COVID-19 public health emergency; to provide for the liability of certain property owners; to provide for the liability of certain natural and juridical persons; to provide for the liability of state and local governments and political subdivisions; to provide for liability related to the design, manufacture, distribution, use, and administration of personal protective equipment; to provide for the rights of employees; to provide for liability related to business operations; to provide for claims pursuant to the Louisiana Workers' Compensation Law; to provide for retroactive application; to provide an effective date; and to provide for related matters.

• The aim of this Emergency Rule is to temporarily add additional codes for the purpose of delivering care and allowing providers to use telemedicine/telehealth methods. This does not affect current existing CPT codes. See [2020 LA REG TEXT 555658](#) (NS).

**Maine**

The emergency adoption of amendments to 10-144 CMR ch. 258 immediately implements (1) requirements for designated health care facilities to report the number and type of available beds and medical supply inventory (i.e. personal protective equipment, pharmaceuticals, ventilator machines) to improve emergency management operations, following the Governor's proclamation, Proclamation of State of Civil Emergency to Further Protect Public Health (March 15, 2020) and authorized by Public Law 2020 ch. 617, An Act to Implement Provisions Necessary to the Health, Welfare and Safety. See [2020 ME REG TEXT 555279](#) (NS).

**Massachusetts**

• **2019 MA S.B. 2708** (NS), introduced May 18, would address COVID-19 data collection and disparities in treatment.

• **2019 MA S.D. 2949** (NS), draft/request May 18, to prevent COVID-19 deaths in senior living facilities, would require each assisted living residence and long-term care facility to provide diagnostic testing and screening of all personnel at least twice a week, written policies ensuring that all personnel undergo COVID-19 screening at the start of each shift, offer each resident to arrange for COVID-19 diagnostic testing; and report all positive results to state and local agencies within 12 hours of receipt.

• **2019 MA H.D. 5108** (NS), draft/request May 27, requiring COVID-19 or infectious disease recovery center notice to nursing facility residents.

• The Center for Health Information and Analysis (CHIA) is issuing this Administrative Bulletin pursuant to 957 CMR 6.20 to notify ambulance and chair car services providers of the revised due dates for the 2019 Ambulance and Chair Car Services Cost Report. See [2020 MA REG TEXT 554854](#) (NS).
Michigan

- **2019 MI H.C.R. 24** (NS), introduced May 27, a concurrent resolution to demand that the Governor compile and make publicly available certain data, to encourage medical professionals to provide elective medical procedures, and to encourage the people of Michigan to continue to practice safe social distancing.

- **2019 MI S.C.R. 26** (NS), engrossed May 28, a concurrent resolution to demand that the Governor compile and make publicly available certain data, to encourage medical professionals to provide elective medical procedures, and to encourage the people of Michigan to continue to practice safe social distancing.

- **2019 MI S.B. 944** (NS), introduced May 28, to create a coronavirus task force on racial disparities.

- **2019 MI H.B. 5785** (NS), introduced May 19, to provide for testing; subsequent testing requirements following a positive COVID-19 test.

Minnesota

- **2019 MN S.F. 4500** (NS), engrossed May 16, COVID-19 serological testing grant program establishment and appropriation.

- **2019 MN H.F. 4693** (NS), introduced May 17, persons engaged in health care services provided criminal, civil, and administrative immunity.

Mississippi


Nevada

- A regulation relating to health insurance; requiring a health insurer to provide certain coverage and information relating to COVID-19; and providing other matters properly relating thereto. See [2020 NV REG TEXT 553872](NS).

New Jersey


- **2020 NJ S.B. 2483** (NS), introduced May 14, would require licensed providers of long-term skilled nursing care to establish permanent morgue for use in non-emergent periods and supplemental morgue space for use in public emergencies.


- **2020 NJ S.B. 2495** (NS), introduced May 28, authorizes elective surgeries and invasive procedures to be performed during coronavirus disease 2019 (COVID-19) emergency.

- **2020 NJ A.B. 4150** (NS), introduced May 14, requires hospitals and long-term care facilities to maintain 90-day supply of personal protection equipment during coronavirus disease 2019 pandemic.

- **2020 NJ A.B. 4156** (NS), introduced May 14, protects health care professionals from retaliatory action by employers and permits health care professionals to refuse to perform certain services onsite at certain times during ongoing coronavirus disease 2019 pandemic.

- **2020 NJ A.B. 4169** (NS), introduced May 28, protects health care professionals from retaliatory action by employers during ongoing coronavirus disease 2019 pandemic.

- **2020 NJ A.B. 4170** (NS), introduced May 28, restricts use of certain data collected for purposes of contact tracing related to COVID-19 pandemic.
• **2020 NJ A.B. 4173** (NS), introduced May 28, requires health care facilities to screen health care workers, first responders, and other frontline workers for symptoms of post-traumatic stress disorder related to COVID-19 pandemic.

**New York**

• To waive copayments, coinsurance, and annual deductibles for essential workers for in-network outpatient mental health services. See **2020 NY REG TEXT 554887** (NS).

**North Carolina**

• **2019 NC H.B. 1210** (NS), introduced May 27, providing coronavirus relief funds to Triangle Residential Options for Substance Abuse, Inc.
• The Department of Health and Human Services submitted a formal request that the Board of Nursing adopt emergency rules with respect to nurses with prescribing authority to assist in alleviating shortages and ensure that these drugs are available to patients who need them. See **2020 NC REG TEXT 554778** and 21 NCAC 33.0113.
• The Department of Health and Human Services submitted a formal request that the Board of Nursing adopt emergency rules with respect to nurses with prescribing authority to assist in alleviating shortages and ensure that these drugs are available to patients who need them. See **2020 NC REG TEXT 554779** (NS) and 21 NCAC 36.0817.

**Pennsylvania**

• **2019 PA S.B. 1122** (NS), amended/substituted May 28, further providing for funds; and, in grants to fire companies and emergency medical services companies, providing for COVID-19 Crisis Fire Company and Emergency Medical Services Grant Program.
• **2019 PA H.B. 2437** (NS), amended/substituted on May 26, 2020, the Emergency Declaration Data Transparency Act, would require long-term care, nursing facilities, hospices, personal care homes, and assisted living residences to report, in relation to COVID-19, the number and results of care recipients and employees who have been tested and the number of deaths among recipients and employees, along with the total number of recipients who reside in the facility and the total number of employees; make available data showing the number of recipients and employees who have tested positive and who have died in each facility as a result of COVID-19.
• **2019 PA H.B. 2509** (NS), amended/substituted on May 26, would establish the Long-Term Care Facility Personal Protective Equipment Reimbursement Grant Program, administered by the Department of Aging.
• **2019 PA H.B. 2510** (NS), amended/substituted May 19, providing for regional response health collaborations to promote health in facilities by supporting COVID-19 readiness and response and improving the quality of infection prevention; and making emergency appropriations for human services.
• **2019 PA H.B. 2534** (NS), introduced May 19, the Communicable Disease Reporting Act, providing for the disclosure of communicable diseases in long-term care, hospice, and certain other facilities during disaster emergencies.
• **2019 PA H.B. 2543** (NS), amended/substituted May 26, providing for COVID-19 testing in long-term care facilities and for duties of the Department of Health and Department of Human Services.
• **2019 PA H.B. 2546** (NS), introduced May 26, would amend the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929, providing for COVID-19 Good Samaritan Emergency Liability Waiver.

**South Dakota**

• Amend rules to update clinical competency examination requirements due to the COVID-19 impact; update radiography administrative rules, training programs, and registration
requirements; remove redundant regulations and obsolete provisions; and update references. See 2020 SD REG TEXT 555661 (NS).

- Governor Noem has signed Executive Order 2020-24, dated May 18, 2020, suspending the rule governing on-site visits of Level IV and Level V trauma hospitals during the emergency and suspending the statute for the annual inspection of funeral establishments, in response to the COVID-19 pandemic. See 2020 SD REG TEXT 555664 (NS).

**Texas**
The Executive Commissioner of the Health and Human Services Commission (HHSC) adopts on an emergency basis in Title 25, Texas Administrative Code, Chapter 448 Standard of Care, amendment of s.448.911, concerning an emergency rule in response to COVID-19 in order to expand a licensed Chemical Dependency Treatment Facility's ability to provide treatment services through electronic means to adults and adolescents and reduce the risk of COVID-19 transmission. See 2020 TX REG TEXT 555390 (NS).

**Virginia**

**Washington**
- WAC 246-834-050 Examination requirements for licensure as a midwife, WAC 246-834-060 Initial application requirements for licensure as a midwife, and WAC 246-834-160 Student midwife permit. In response to the coronavirus disease 2019 (COVID-19) pandemic, the Department of Health is amending requirements for examination for midwifery applicants. See 2020 WA REG TEXT 554941 (NS).
- The department is temporarily amending portions of the rules listed below to ensure assisted living facilities are not significantly impeded during the hiring process due to an administrator's inability to obtain a certificate of completion of a recognized administrator training as referenced in WAC 388-78A-2521. This will help to increase the number of long-term care administrators necessary to provide essential services to some of Washington's most vulnerable adults during the outbreak of COVID-19. See 2020 WA REG TEXT 554942 (NS).
- The Nursing Care Quality Assurance Commission is adopting emergency rules in response to the coronavirus disease (COVID-19). These rules apply to the specific regulatory requirements for LPNs, RNs and ARNPs. The amendments remove specific barriers that nurses face to providing care in response to COVID-19. See 2020 WA REG TEXT 554944 (NS).
- The Department of Health is adopting an emergency rule to amend WAC 246-310-806(1) as it relates to special and nonspecial circumstances 1 concurrent review cycle. The amendment extends deadlines for kidney disease treatment facility applicants who are submitting applications during concurrent review cycle 1. This extension grants flexibility in meeting deadlines during the current public health emergency created by the coronavirus disease 19 (COVID-19) pandemic. See 2020 WA REG TEXT 554948 (NS).
- The department is amending the rules listed below to ensure nursing homes are not significantly impeded from admitting and caring for residents during the COVID-19 outbreak. These amendments will align state nursing home rules with federal rules that were suspended or amended to help facilitate care during the COVID-19 pandemic. The federal rules were amended to allow physicians to delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist. See 2020 WA REG TEXT 554950 (NS).
• The department is creating WAC 388-434-0015 Extension of certification periods and waiver of eligibility reviews and mid-certification reviews during the COVID-19 pandemic. This emergency rule adoption supports ongoing access to public assistance and provides administrative flexibility, allowing extension of certification periods and waiver of eligibility reviews and mid-certification reviews, during this time of economic hardship resulting from the public health crisis created by the coronavirus. See 2020 WA REG TEXT 554953 (NS).

• The Health Care Authority in conjunction with the aging and long-term support administration in the Department of Social and Health Services, intends to submit Medicaid SPA 20-0019 in order to increase the Medicaid rates for nursing facilities. The change proposed to take effect May 1, 2020, is due to state legislation that added an inflationary factor to the direct care and indirect care components. In addition, nursing facility rates are proposed to increase on July 1, 2020, due to an increase in appropriation from the state legislature. See 2020 WA REG TEXT 554976.

FEDERAL ADMINISTRATIVE ACTIONS

FDA Informs Public About Possible Accuracy Concerns with Abbott ID NOW Point-of-Care Test
On May 14, the FDA alerted the public to early data that suggest potential inaccurate results from using the Abbott ID NOW point-of-care test to diagnose COVID-19. Specifically, the test may return false negative results.²

“We are still evaluating the information about inaccurate results and are in direct communications with Abbott about this important issue. We will continue to study the data available and are working with the company to create additional mechanisms for studying the test. This test can still be used and can correctly identify many positive cases in minutes. Negative results may need to be confirmed with a high-sensitivity authorized molecular test,” said Tim Stenzel, M.D., Ph.D., director of the Office of In Vitro Diagnostics and Radiological Health in the FDA’s Center for Devices and Radiological Health.

The FDA is sharing early information available about potential inaccurate results in the spirit of transparency. The agency has been working with Abbott to analyze the information gathered to date and has worked with the company on a customer notification letter to alert users that any negative test results that are not consistent with a patient’s clinical signs and symptoms or necessary for patient management should be confirmed with another test.

Moving forward, Abbott has agreed to conduct post-market studies for the ID NOW device that each will include at least 150 COVID-19 positive patients in a variety of clinical settings. The FDA will continue to review interim data on an ongoing basis. The information gathered from the post-market studies can further help the agency understand the cause or patterns of any accuracy issues and inform any additional actions the company or the FDA should take. The FDA will keep working with Abbott to further evaluate these accuracy issues and will publicly communicate any updates.

FDA Authorizes First Standalone At-Home Sample Collection Kit That Can Be Used With Certain Authorized Tests
On May 16, the FDA authorized an at-home sample collection kit that can then be sent to specified laboratories for COVID-19 diagnostic testing. Specifically, the FDA issued an
emergency use authorization (EUA) to Everlywell, Inc. for the Everlywell COVID-19 Test Home Collection Kit. Everlywell’s kit is authorized to be used by individuals at home who have been screened using an online questionnaire that is reviewed by a health care provider. This allows an individual to self-collect a nasal sample at home using Everlywell’s authorized kit. The FDA has also authorized two COVID-19 diagnostic tests, performed at specific laboratories, for use with samples collected using the Everlywell COVID-19 Test Home Collection Kit. These tests have been authorized under separate, individual EUAs. Additional tests may be authorized for use with the Everlywell at-home collection kit in the future, provided data are submitted in an EUA request that demonstrate the accuracy of each test when used with the Everlywell at-home collection kit.

“The authorization of a COVID-19 at-home collection kit that can be used with multiple tests at multiple labs not only provides increased patient access to tests, but also protects others from potential exposure,” said Jeffrey Shuren, M.D., J.D., director of the FDA’s Center for Devices and Radiological Health. “Today’s action is also another great example of public-private partnerships in which data from a privately funded study was used by industry to support an EUA request, saving precious time as we continue our fight against this pandemic.”

The Everlywell home-collection kit is currently the only authorized COVID-19 at-home sample collection kit for use with multiple authorized COVID-19 diagnostic tests. The kit and associated tests are available by prescription only.

Federal Guidance for Nursing Home Reopenings
The Centers for Medicare & Medicaid Services (CMS) issued recommendations\(^3\) to help state and local officials determine the level of mitigation needed to prevent the transmission of COVID-19 in nursing homes. The recommendations cover the following factors:

- Criteria for relaxing certain restrictions and mitigating the risk of resurgence: factors to inform decisions for relaxing nursing home restrictions through a phased approach.
- Visitation and service considerations: considerations allowing visitation and services in each phase.
- Restoration of survey activities: Recommendations for restarting certain surveys in each phase.

Nursing home residents and staff members must receive baseline COVID-19 test results before relaxing any restrictions or advancing through phases of reopening, according to the guidance, issued on May 18, 2020. Also, prior to reopening, state survey agencies are required to inspect nursing homes that have experienced a significant COVID-19 outbreak. CMS recommends that nursing homes be among the last to reopen within the community, even as other businesses begin to reopen.

The agency also noted in its guidance that decisions to relax restrictions in nursing homes should factor in the case status in the local community and the facility, if a provider has adequate staffing, access to adequate testing, whether universal source control measures can be followed (including face coverings for residents and visitors, social distancing, and hand washing or sanitizing upon entry to the facility), local hospital capacity, and if the facility has enough personal protective equipment.

CMS Issues Fact Sheet for State and Local Governments on Seeking Payment for Services Rendered at Alternate Care Sites

The COVID-19 pandemic created a heightened need for space to treat patients, and many state and local governments and hospitals developed alternate care sites (ACS) to meet that need. The Centers for Medicare and Medicaid Services (CMS) defines an ACS as “any building or structure that is temporarily converted or newly erected for healthcare use,” and the Federal Healthcare Resilience Task Force developed a toolkit for creating such spaces. CMS has now developed a Fact Sheet for state and local governments describing how they can request and receive Medicaid, Medicare, and CHIP payment for services rendered at ACSs. CMS offers this “key takeaway”:

The easiest path to obtaining payments through CMS programs for covered health care services furnished at the ACS is for an already-enrolled hospital or health system to treat the ACS as a temporary expansion of their existing ‘brick-and-mortar’ location. In these circumstances the local hospitals and health systems operate, staff, and bill for care furnished at the ACS. State and local governments that want to establish (meaning to develop or build) a hospital ACS, and be paid by CMS for furnishing covered hospital inpatient and outpatient services to enrolled beneficiaries, have three options:

1) hand over operation and billing for care delivered in the ACS to an enrolled hospital or health system;
2) enroll the ACS as a new hospital in CMS programs; or
3) if options (1) and (2) are not available, CMS would not make facility payments, but qualified and enrolled physicians or other non-physician practitioners could bill for covered (professional) services that they furnish at the ACS.

OTHER NEWS AND SUMMARIES

Universal Testing at Nursing Homes Would Cost $440 million, AHCA/NCAL Says

It would cost about $440 million nationwide to test every nursing home resident and staff member just once in the United States, according to data compiled by the American Health Care Association/National Center for Assisted Living (AHCA/NCAL). The state-by-state breakdown of the testing costs, released on May 20, 2020, did not include the cost of testing residents and staff in assisted living or other long-term care facilities. In all, 15,429 nursing facilities would be tested, comprising 1,327,678 residents and 1,603,800 staff members, totaling 2,931,478 tests, estimated at $150 per test. AHCA/NCAL concluded that regular testing of nursing home residents and staff would be unsustainable without federal or state funding.

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**Alternative Payment Models Helped with Management of COVID-19**

A recent survey showed that participants in alternative payment models (APMs) used their population health capabilities to help manage the COVID-19 pandemic.

Premier Inc., a healthcare improvement company, conducted the survey.

Researchers found that 82 percent of APM participants utilized care management support to manage COVID-19 patients and other patients. Fifty-one percent of healthcare providers not in APMs used care management support.

The results of the survey also showed:
- 55 percent of APM participants use triage call centers (versus 31 percent of all others),
- 49 percent use remote monitoring (versus 30 percent of others),
- 43 percent use population health data to manage and predict cases (versus 20 percent of others) and
- 29 percent use claims data to understand care delivered outside the acute setting (versus 13 percent of others).

“Respondents participating in APMs had a significant head start over other healthcare providers in being able to provide quality and preventive care for their covered lives, all while managing an influx of emergency COVID-19 cases,” said Joe Damore, Premier Vice President of Population Health. “The sad paradox is that all these commendable efforts may come with a heavy cost. Added investments and increased utilization of hospital emergency services, as well as increases planned to clear the backlog of elective procedures that were delayed during the COVID-19 peak period, could drive the total cost of care up. This could lead to penalties in some Medicare and many commercial APMs – even though the pandemic was beyond the participants’ control.”

Fifty-four percent of the survey respondents in two-sided risk APM models across all payers predicted that they would incur losses that will require repayment to some payers because of the surge in COVID-19 patients.

The expense of treating higher acuity patients seeking care will also add costs.

Eighty-five percent of those same respondents indicated that they experienced fee-for-service revenue reductions of 30 percent or more because of cancellations in ambulatory care visits and elective or diagnostic procedures.

“While the exact losses and penalties incurred are still open questions, there’s no doubt that some relief must be provided to APM participants,” noted Damore. “The absolute last thing we want is for a pandemic to result in financial penalties that exacerbate an already dire financial situation for many of America’s healthcare providers as a result of months of lost revenue from planned admissions. Action is needed to keep a focus on the movement to value-based care, preserving the progress and investments made to date.”

Premier has encouraged the Centers for Medicare & Medicaid Services (CMS) to assist APM participants by:
- Allowing organizations in APMs to move to no downside financial risk with modified upside risk, recognizing that losing the opportunity to achieve full shared savings would only compound financial hardships experienced due to COVID-19;
• Implementing CMS “extreme and uncontrollable circumstances” models across all CMS Innovation Center programs, allowing model participants to maintain their current status;
• Accelerate pending shared savings and MACRA bonus payments to healthcare providers to help meet cash flow challenges;
• Converting all quality measures to pay for reporting; and
• Allowing all accountable care organizations 90 days to determine if they want to drop out of the program without penalty in 2020.

Other measures requested by survey respondents included making temporary waivers granted by CMS due to the pandemic permanent payment policy for APMs. Ninety-three percent of respondents wanted telehealth waivers to become permanent. These waivers fully reimburse providers for virtual patient care visits for Medicare beneficiaries.

Fifty-nine percent of respondents requested that workforce flexibility waivers become permanent. These waivers allow health systems to use nurse practitioners and physician assistants for routine tasks to free physicians to care for the most acute patients.

Fifty-nine percent of respondents also wanted the skilled nursing facility (SNF) three-day rule that waives the requirement for a three-day inpatient hospital stay prior to admission into a Medicare-covered SNF to become permanent policy.8

**Wisconsin Announces Federal Grant for HCBS Providers**

Wisconsin Governor Tony Evers (D) has announced a $100 million grant funded by the federal Coronavirus Aid, Relief and Economic Security (CARES) Act to support providers most at risk during the COVID-19 pandemic.9 It applies to providers of emergency medical services, home and community-based services and long-term care, including skilled nursing and assisted living facilities.

The program will be administered in two parts: an initial release of funds to support immediate needs, and a second, targeted release for additional needs of individual providers. Both rounds of funding will be allocated to support expenses directly related to COVID-19 as well as expenses associated with the interruption of typical operations, such as overtime pay, changes to sanitation procedures, and disruption to the standard delivery of care.

EMS, LTC and HCBS providers have been on the frontline during the pandemic and ensure that the elderly and people with disabilities can safely stay in their homes and communities. They are facing significant challenges with increased expenses having to purchase more personal protective equipment and retaining workers.

**Nevada Health Link Enrolls Over 6,000 During Special Enrollment Period**

The Silver State Health Insurance Exchange, Nevada’s health insurance exchange, enrolled over 6,000 state residents in health insurance coverage through the online marketplace during a special enrollment period due to the COVID-19 pandemic.

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9 Rebecca Kanable, $100 million for long-term care, home- and community-based services and EMS, Milton Courier (May 21, 2020) at: https://www.hngnews.com/milton_courier/news/covid-19/article_0a1d0183-a240-5fcc-bf48-deb1be92fd81.html.
The limited Exceptional Circumstance Special Enrollment Period (SEP) ran from March 17 through May 15. Enrollment included 5,479 new consumers.

The remaining 538 enrollments were due to loss of Minimum Essential Coverage (MEC).

Governor Sisolak’s March 12 Emergency Declaration led to the opening of the SEP to eligible Nevada residents to access health insurance coverage. Consumers enrolling April 30 or before obtained coverage beginning on May 1. Consumers enrolling between May 1 and May 15 received coverage beginning June 1.

“I am pleased to see so many Nevadans take advantage of the limited-time Special Enrollment Period to get comprehensive, qualified health insurance they need to safeguard themselves and their families, especially during these unprecedented times,” said Gov. Steve Sisolak. “While it’s always important to be insured, regardless of age, health, income or life circumstances, the global coronavirus pandemic has certainly magnified the importance of healthcare coverage and the invaluable peace-of-mind that comes with knowing you are covered and protected should you or someone in your family become ill or injured.”

Nevada operates its own health insurance exchange under the Affordable Care Act, which allowed the state to open a special enrollment period for state residents. Nevada and 12 other states operate their own exchange, allowing the option of a special enrollment period that was not available to states depending on the federal government to run a health insurance exchange for their residents.

The plans available through the Nevada exchange cover the diagnosis and treatment of COVID-19 as well as the ten essential health benefits mandated under the Affordable Care Act.¹⁰

**California Health Insurance Exchange Sees Special Enrollment Surge**

The health insurance exchange in California, Covered California, announced that 123,810 people had enrolled in health insurance coverage during the special enrollment period opened in response to the COVID-19 pandemic.

The pace of enrollment was almost 2.5 times higher than the level of enrollment during the same period last year.

“When the worst is happening in people’s personal economic lives, we want to make sure that Californians know they can have the peace of mind that comes with quality health care coverage,” said Peter V. Lee, executive director of Covered California. “Whether Californians have lost job-based health insurance coverage, or they were uninsured when this pandemic began, our doors are wide open to help them get coverage through either Covered California or Medi-Cal.”

The data came from the period of March 20 through May 16. Covered California opened the health insurance exchange to eligible individuals without health insurance coverage because of the pandemic. The special enrollment period will end June 30.

The eligibility requirements during the special enrollment period are similar to requirements during the annual open-enrollment period.

Special enrollment periods are available to California residents year-round if they are eligible and experience a qualifying life event. The events include losing health care coverage, moving, getting married, or having a child.

Earlier in 2020, Covered California held a special enrollment period to consumers to account for the new state financial assistance for health insurance coverage and the new state penalty for going without insurance.

From the end of the regular open-enrollment period in the state on January 31 through May 16, 191,380 California residents signed up for coverage, almost two times as many who signed up during the same period last year.

The health insurance exchange created a new fact sheet to educate consumers about their health insurance options if their employment or coverage has been affected by the COVID-19 pandemic.

It contains information about Covered California, Medi-Cal and COBRA. It also educates consumers about the enrollment process.

Coverage for people who sign up through Covered California begins on the first day of the following month. People eligible for Medi-Cal are covered retroactively on the first day of the month they applied.

Consumer assistance is also available via phone from a team of Certified Insurance Agents through Covered California.

“In this time of social distancing, people should know that health insurance is only a phone call away,” Lee said. “Consumers can get free and confidential assistance from certified agents or one of Covered California’s trained professionals while remaining safe and protecting themselves and their families.”

The website offers a Shop and Compare Tool to help consumers choose a plan based on ZIP code, income, and ages of people in the household needing health insurance coverage. The website also helps consumers determine if they are eligible for Covered California or Medi-Cal.11

HHS Announces Nearly $4.9 billion Distribution to Nursing Facilities Impacted by COVID-19

On May 22, the U.S. Department of Health and Human Services (HHS) announced that it has begun distributing billions in relief funds to skilled nursing facilities (SNFs) to help them combat the devastating effects of the COVID-19 pandemic. An HHS news release points out that during this pandemic, nursing homes have faced unique challenges, as their population of high-risk seniors are more vulnerable to respiratory pathogens like COVID-19.12 The


funding, which supplements previously announced provider relief funds, is to be used to support nursing homes facing significant expenses or lost revenue attributable to COVID-19.

Support for healthcare providers fighting the COVID-19 pandemic is provided through the bipartisan CARES Act and the Paycheck Protection Program and Health Care Enhancement Act, which supplies $175 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response.

The COVID-19 pandemic has impacted the viability of SNFs in a variety of ways. Since the beginning of 2020, SNFs have experienced up to a 6 percent decline in their patient population as current and potential residents choose other care settings, or as current residents pass away, the press release notes. In addition to nursing home residents, many SNF employees have also been diagnosed with COVID-19. These additional funds may help nursing homes address critical needs such as labor, scaling up their testing capacity, acquiring personal protective equipment and a range of other expenses directly linked to this pandemic.

According to the release, HHS will make relief fund distributions to SNFs based on both a fixed basis and variable basis. Each SNF will receive a fixed distribution of $50,000, plus a distribution of $2,500 per bed. All certified SNFs with six or more certified beds are eligible for this targeted distribution. Nursing home recipients must attest that they will only use Provider Relief Fund payments for permissible purposes, as set forth in the Terms and Conditions, and agree to comply with future government audit and reporting requirements.

**Drug Costs Related to COVID-19 to Affect Different People in Different Ways Based on Insurance Status**

The Kaiser Family Foundation (KFF) recently published a review of the steps taken by states, Congress, the Trump Administration, and private insurance plans to address affordability issues relating to timely access to COVID-19 testing and treatment.

KFF broke the issues down into testing, treatment, preventative care, inability to afford care, and the effects of potential economic downturns. Each issue addresses, to some degree, cost savings matters relating to drugs and COVID-19.

Because of the Families First Coronavirus Response Act (FFCRA), most people should not incur costs for the COVID-19 test. Starting on March 18 and lasting for the duration of the public health emergency, all forms of public and private insurance, including self-funded plans, must now cover FDA-approved COVID-19 tests and costs associated with testing with no cost-sharing. This includes high-deductible health plans and grandfathered plans.

Medicare also covers serology tests that can determine whether an individual has been infected with SARS-CoV-2, the virus that causes COVID-19, and developed antibodies to the virus. The FFCRA also included an option for states to cover testing for the uninsured through Medicaid with 100% federal financing.

Furthermore, $2 billion was allocated to reimburse providers for testing-related costs for uninsured individuals through the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program.

The Centers for Medicare and Medicaid Services has announced that Medicare will reimburse providers up to $100 per test, depending on the test. Newer COVID-19 tests that give results more quickly may cost providers more than the early tests. Several private
providers, including some that take no insurance, are charging substantially more than $100 for COVID-19 tests.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act also expanded protections by requiring private plans to fully cover out-of-network tests. The CARES Act, however, does not prohibit out-of-network providers from billing patients directly for the COVID-19 test. This fact could deter some patients from obtaining a test.

Unlike federal laws relating to testing, there has not yet been comprehensive federal legislation to limit cost-sharing for treatment of COVID-19, such as hospitalization and related prescription drugs for patients who become very ill with the disease.

Most major insurers have voluntarily waived some or all treatment costs. For self-funded plans, employers ultimately decide whether treatment costs will be covered, and the degree to which they will be covered.

Although there is currently no approved vaccine to prevent COVID-19, the coronavirus funding package passed on March 6, 2020 noted that, if a vaccine is developed, it should be priced “fairly and reasonably.” If a vaccine for COVID-19 is approved, recommended, and made widely available, it will likely be covered for nearly all insured people without cost-sharing. The Affordable Care Act includes a requirement that federally-recommended preventative care be covered without cost-sharing for anyone enrolled in private insurance, Medicare, or in the Medicaid expansion.

Insurers are generally given at least one year to implement these recommendations, but the CARES Act requires plans to cover any coronavirus-related preventative care without cost-sharing within 15 days of a recommendation from the USPSTF and ACIP.

Under the FFCRA, states must cover COVID-19 vaccine costs for all Medicaid enrollees without cost sharing to be eligible for the enhanced matching funds available through the public health emergency.

Covering the costs of the vaccine for uninsured individuals has yet to be addressed by the federal government.

The CARES Act expedites the process for designating a coronavirus vaccine and testing as federally-recommended preventative care to be covered in private insurance without cost-sharing. This Act also provides for coverage of any eventual coronavirus vaccine under Medicare Part B with no cost-sharing. This requirement applies to beneficiaries in both traditional Medicare and Medicare Advantage plans.

Because of the economic crisis related to COVID-19, more people are likely to qualify and enroll in Medicaid. In states that adopted the Medicaid expansion, adults (both parents and childless adults) with incomes up to 138% FPL could be eligible for Medicaid. In states that have not adopted the expansion, eligibility for parents is generally well below poverty level and childless adults are not eligible for coverage (except in Wisconsin).

Children in unemployed families will likely be newly eligible for Medicaid or the Children’s Health Insurance Program (CHIP), which is open to children with family income at or well above 200% of FPL in nearly all states.

Unlike coverage in the Marketplace, there is no open-enrollment period for Medicaid, and individuals can apply at any time. Medicaid eligibility is based on current monthly income.
State unemployment benefits are counted as income for Medicaid eligibility, but new federal supplemental unemployment benefits are excluded from income for purposes of determining Medicaid eligibility.\(^{13}\)

**AHCA CEO: On-site COVID-19 Testing Could Be Key to Reducing “Horrible” Isolation Facing Residents**

American Health Care Association (AHCA) President and CEO Mark Parkinson says there are two keys to safely reuniting eldercare facility residents and their families after COVID-19 lockdowns: bringing infection numbers down in adjacent communities, and universal testing that includes on-site visitor tests, *McKnight's* reports.\(^{14}\) In a Sunday Fox News interview, Parkinson was asked what scenario would allow residents and families to reconnect. He acknowledged the devastating consequences of facility lockdowns on residents’ quality of life. Despite staff attempts to connect families virtually through apps like Facetime, “there’s just no alternative to being together, and then the tragic scenes of people dying without their loved ones … it’s horrible,” he said.\(^{15}\)

When determining whether to open facilities, the leading consideration must be infection levels in surrounding communities, as this will determine the risk level inside an eldercare facility, he said. Adequate testing of all staff and residents will offer further protection, he added. And the “ideal” situation would be the addition of “on-site testing throughout the summer,” he concluded. “[W]e do recognize it’s extremely important to get these folks back with their families.”

**Pandemic Hits Hospice Revenues**

A majority of hospice providers (60%) anticipate a decrease in annual revenues in 2020, according to recent research conducted by the National Association for Home Care & Hospice (NAHC).\(^{16}\) The survey, which was conducted over the first three weeks of May 2020, sought information on a broad range of issues, including the extent to which hospices have employed telecommunications technology to help meet patient care needs.

Among the contributing factors to revenue drops is a decline in hospice patient admissions and referrals amid the public health emergency. While nearly two-thirds (61 percent) of hospices that responded to the NAHC survey have admitted confirmed COVID-19-positive patients on to service, more than half of respondents saw a decrease in admissions during March 2020 as compared with March 2019. More than a quarter saw a 15% drop or more. Nearly 71% of the hospices reported declining referrals and admissions from nursing facilities, along with 63% experiencing declines in hospital referrals and roughly half seeing a decrease from community referral partners.

A majority of the providers also cited increased costs of supplying staff with personal protective equipment (PPE), with hospices calling for more federal funding of PPE supplies among increased costs and high demand.

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\(^{15}\) The interview is available in its entirety on Youtube, at [https://www.youtube.com/watch?v=ubmPMQvk4I](https://www.youtube.com/watch?v=ubmPMQvk4I).

Not surprisingly, according to the report, more than 95% of hospices have had existing patients refuse visits due to fears associated with risk of exposure to COVID-19. And while hospices have been able to provide technology-based visits to continue patient care in some cases, nearly 24 percent of the hospices in the survey were able to substitute virtual visits in only limited or no cases. A large proportion—more than 84 percent—of hospices participating in the survey are using telecommunications technology to provide services to Medicare hospice patients and a similar proportion (approximately 82 percent) use two-way audio-visual communications (among other technologies) for patient care.

**International Biopharmaceutical Organization Discusses Industry Obligations in Light of Search for COVID-19 Vaccine**

The International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) recently provided a media update on the biopharmaceutical industry’s efforts to increase research and development for a new COVID-19 vaccine. The organization also noted that plans are underway to scale up manufacturing at risk even though it is not sure yet which, if any, vaccines in development will be found to be safe and effective. According to the IFPMA, such investment decisions are “unprecedented” and demonstrate that companies are not taking a “business as usual” approach in their response to the global pandemic.

The industry reaffirmed its awareness of its responsibility towards patients and society to use its knowledge and expertise, in collaboration with others, in finding a coronavirus vaccine that is safe and effective.

As of May 27, 2020, the WHO reported there are currently ten candidate vaccines in clinical evaluation and 115 candidate vaccines in pre-clinical evaluation. Several biopharmaceutical companies are researching vaccine candidates and are collaborating in the sharing of existing technologies. These shared technologies are intended to allow a rapid upscale of production once a vaccine candidate is identified. Companies are also sharing technologies that act as an adjuvant, which can boost the effectiveness of a potential vaccine.

Thomas Cueni, IFPMA Director General, noted that, “Not only does the science have to be on our side if we are to quickly find a coronavirus vaccine, but we also have to find ways of being able to produce hundreds of millions, possible billions of doses of the new vaccine. Then people need to be vaccinated in sufficient numbers to protect whole communities. And, all the while, we should continue to produce existing vaccines."

Mr. Cueni also stated that, “The only way to deliver on our promise of safe, equitable, affordable coronavirus vaccines is for science and collaboration on a global scale to prevail. Be in no doubt, our member companies are fully engaged in the race to find a vaccine. We are fully committed to playing our full role within existing partnerships, such as ACT Accelerator and Gavi, on the basis that we wholeheartedly embrace the goal of providing new coronavirus vaccines for all.”

**ACO Announces $5 Million Campaign for Telehealth in Response to COVID-19**

Community Care Cooperative (C3), the Accountable Care Organization (ACO) serving MassHealth members, announced a $5 million campaign focused on increasing telehealth capacity in community health centers throughout Massachusetts.

The campaign is aimed at combatting the COVID-91 pandemic as well as improving service for health center patients overall.

According to the organization, “It’s taken a worldwide public health crisis to illustrate just how much we need telehealth and how valuable it is in serving the needs of patients everywhere.”

C3 indicated that it had received an award of grants from the Federal Communications Commission’s (FCC) Wireline Competition Bureau, charitable foundations and individuals totaling approximately $2.8 million to advance telehealth in Massachusetts in response to COVID-19.

“With the social distancing required to fight COVID-19, telehealth has become an absolute necessity in providing primary and dental care, and we urgently need to extend that access to the most vulnerable of Massachusetts’s residents,” said Christina Severin, President and CEO of C3. “With the generous support we are announcing today, we come closer to our $5 million campaign goal and greatly increase our capacity to help our community health centers to better serve the needs of the commonwealth’s Medicaid patients.”

REGULATORY INTELLIGENCE AND REUTERS NEWS

FDA Suspends Gates-backed At-home COVID-19 Testing Program
(Reuters) - An at-home coronavirus testing project in Seattle backed in part by the Bill and Melinda Gates Foundation said on Saturday it was working with U.S. regulators to resume the program after being suspended by the Food and Drug Administration.

The Seattle Coronavirus Assessment Network (SCAN), which aims to monitor the spread of the novel coronavirus in the region, had said it was suspending its testing of patient samples collected at home after the Food and Drug Administration tightened guidelines to require emergency approval first.

“The FDA has not raised any concerns regarding the safety and accuracy of SCAN’s test, but we have been asked to pause testing until we receive that additional authorization,” SCAN said.

The Gates Foundation in March said it was providing technical assistance for SCAN, which had been approved by regulators in Washington state, one of the first U.S. states to be hit hard by the outbreak. Bill Gates has also privately funded SCAN, according to the foundation.

On Thursday, SCAN in a statement said it has been in talks with the FDA since March 1 and initiated its request for emergency use authorization (EUA) on March 23, submitting data on April 13.

“We have been notified that a separate federal emergency use authorization is required to return results for self-collected tests,” SCAN said.


Representatives for the Food and Drug Administration did not have an immediate comment on SCAN’s status. Representatives of King County Health Department referred questions to SCAN. SCAN said it did not have an update on specific timing for when testing would restart.

Separately, the FDA on Saturday approved a standalone at-home sample collection kit for Everlywell Inc, a health and wellness company, which launched its kit in March.

**CDC Plans Sweeping COVID-19 Antibody Study in 25 Metropolitan Areas**

(Reuters) - The U.S. Centers for Disease Control and Prevention (CDC) plans a nationwide study of up to 325,000 people to track how the new coronavirus is spreading across the country into next year and beyond, a CDC spokeswoman and researchers conducting the effort told Reuters.20

The CDC study, expected to launch in June or July, will test samples from blood donors in 25 metropolitan areas for antibodies created when the immune system fights the coronavirus, said Dr. Michael Busch, director of the nonprofit Vitalant Research Institute.

Busch is leading a preliminary version of the study - funded by the National Heart, Lung and Blood Institute and the National Institute of Allergy and Infectious Diseases - that is testing the first 36,000 samples.

The CDC-funded portion, to be formally announced this week, will expand the scope and time frame, taking samples over 18 months to see how antibodies evolve over time, said CDC spokeswoman Kristen Nordlund.

Vitalant, a nonprofit that runs blood donation centers and tests samples, will lead the broader effort as well.

Researchers aim to publish results on a rolling basis, Nordlund said.

Antibody studies, also known as seroprevalence research, are considered critical to understanding where an outbreak is spreading and can help guide decisions on restrictions needed to contain it.

The CDC study should also help scientists better understand whether the immune response to COVID wanes over time.

The novel coronavirus has infected around 1.5 million people in the United States and killed nearly 90,000, according to a Reuters tally.

The CDC study will test blood from 1,000 donors in each of the 25 metro areas monthly, for 12 months. Researchers will then test blood from another 25,000 donors at the 18-month mark. Samples will come from “regular, altruistic people” who come in to donate blood, Busch said.

‘FEELING EXPOSED’

Some public health officials have complained that the CDC has lagged on research and guidance for local governments trying to cope with the pandemic. “We’re feeling exposed at

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the local level, in terms of not seeing that kind of organized plan from CDC,” Dr. Matt Willis, public health officer for Marin County, California, said in an interview last week.

News of the study brought Willis some reassurance. “Partial answers and preliminary results are better than nothing when you have a decision to make” that could affect lives, he said, like when to reopen parks and businesses.

The CDC’s Nordlund said the study “is indicative of how leaders across the federal government are working collaboratively with partners in academia and in blood donation and testing industries” to monitor COVID-19.

She added that blood donor results can be used by CDC to form estimates about the broader population through statistical methods. “This has been done with West Nile virus, Zika, and other emerging infectious diseases,” she said.

The six metropolitan areas being surveyed in the precursor study are New York, Seattle, the San Francisco Bay Area, Los Angeles, Boston and Minneapolis, said Dr. Graham Simmons, another Vitalant researcher involved in the project. “In all likelihood” the next phase will add Miami, Atlanta, New Orleans, Dallas, St. Louis, Chicago, Denver and others, Simmons said.

“We have selected sites to give a broad geographical distribution throughout the country,” Simmons said, including sites with high infection rates or places where rates may increase.

Researchers at John Hopkins University, in a 2019 paper, found blood donors, who are disproportionately healthy, are not always ideal populations for research.

The CDC study may not “generate results that are generalizable to the population,” Thomas McDade, a researcher at Northwestern University, said in an interview.

Still, it could “substantially add to our understanding of (COVID-19) infections,” said Dr. Susan Philip, deputy health officer at the San Francisco Department of Public Health.

“It will be a large sample size, geographically diverse … and quick to set up,” Philip added.

Some local governments have done their own seroprevalence research. New York in April found antibodies in more than 20% of some 3,000 test subjects, suggesting the number of residents exposed to the virus in the hardest-hit state is much higher than the 355,000 who have tested positive.

Last week, an antibody study by the city of Boston and Massachusetts General Hospital found 10% of the population had COVID-19 antibodies. The Spanish government ran a study showing exposure in 5% of people - suggesting 10 times the number of confirmed positive cases.

As U.S. Moves to Reopen Economy, Nursing Homes Get CMS Guidance on Relaxing Restrictions

(Regulatory Intelligence) - The Centers for Medicare & Medicaid Services (CMS) announced new guidance for state and local officials to ensure the safe "reopening" of nursing homes that have tightly restricted access amid the COVID-19 pandemic. The guidance details the
steps for nursing homes and communities should take before relaxing restrictions in place to prevent the spread of COVID-19.\(^{21}\)

Because of the vulnerable nature of nursing home residents, the steps include rigorous infection prevention and control measures, adequate testing and surveillance. The guidance details three phases of reopening for nursing homes.

As many as 43% of COVID-19 deaths in the U.S. have been in long-term care facilities, according data collected by the Kaiser Family Foundation as of May 28. KFF reported that in two states, Minnesota and Rhode Island, 81% of reported COVID-19 deaths were in nursing homes.

“Our focus continues to be the safety and quality of life of nursing home residents and while we are not at a point where nursing homes can safely open up, we want to make sure communities have a plan in place when they are ready to reopen,” according to CMS Administrator Seema Verma.

CMS recommends that nursing homes do not advance through any phases or reopening or relaxing until all residents and staff have received results from a baseline test.

CMS also recommends that state survey agencies inspect nursing homes that experienced a significant COVID-19 outbreak before such homes take any reopening measures.

Finally, CMS recommends that nursing homes remain in the current state of highest restriction even as communities begin to reopen other businesses with nursing homes being the last to reopen to ensure the safety of residents.

Nursing homes should only begin to receive visitors when there has been a sustained decrease in COVID-19 cases. Visitors must be screened and wear a cloth face covering at all times.

CMS recommends that decisions to relax nursing home restrictions include a careful review of the following facility, community and state factors:

- status of COVID-19 cases in the local community,
- status of COVID-19 cases in nursing homes,
- adequate staffing,
- baseline testing of all residents, weekly testing of all staff, practicing social distancing, and universal source control for residents and visitors (e.g., face coverings),
- access to adequate personal protective equipment (PPE) and
- local hospital capacity.

CMS allows flexibility for states implement the phases either across the whole state at the same time, by region or even at the individual nursing home level.

**Uncertainty Around Pandemic Larger Risk to Life, Health Insurers: Fitch**

(Regulatory Intelligence) - Life and health insurers are the insurance industry sectors most exposed to risks presented by the COVID-19 pandemic, according to U.S. rating agency Fitch.\(^ {22}\)

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\(^{21}\) Melissa D. Berry, As U.S. moves to reopen economy, nursing homes get CMS guidance on relaxing restrictions, Thomson Reuters Regulatory Intelligence, (May 29, 2020) at [http://go ri.tr.com/WNXDIs](http://go ri.tr.com/WNXDIs).

\(^{22}\) Antonita Madonna, Uncertainty around pandemic larger risk to life, health insurers: Fitch, Thomson Reuters Regulatory Intelligence (May 29, 2020) at [http://go ri.tr.com/cBKL0e](http://go ri.tr.tr.com/cBKL0e).
“We are likely in the early stages of what could be a prolonged and severe economic downturn precipitated by this pandemic,” analysts led by Laura Kaster said in a note to clients on Wednesday.

Life insurers -- more exposed to asset stress from capital-markets volatility and to higher mortality risk -- remain vulnerable to the uncertainty associated with the unprecedented and abrupt shutdown of the U.S. economy in response to the pandemic, according to Fitch.

The sector, however, had a strong balance sheet with significant capital and good asset quality and favorable liquidity prior to the onset of the new coronavirus outbreak, it added.

Health insurers, less exposed to a fallout in the capital market, still face “a lot of uncertainty” from the lack of clarity around the true infection rate, the potential for a second wave of infections, and the potential return of deferred care to the healthcare system.

While national insurers are better prepared to absorb losses from this health crisis, a potential loss or shift of enrollment due to the rising unemployment and the threat of more acute-care claims from deferred diagnostic procedures present a risk to the entire health insurance sector.

“We expect a very high level of uncertainty to continue for some time around how the pandemic will run its course, when or if an effective vaccine will be developed and widely administered or whether there will be a second wave of infections as states gradually begin to re-open the economy,” the analysts said.

The uncertainty about the length of the pandemic also presents risk for property and casualty insurers underwriting travel and event cancellations and workers’ compensation among others, they added.

Insurers covering business interruption claims and currently facing pressure from lawmakers to reimburse losses from shutdown orders remain a “key area of contention,” the analysts said. “Successful efforts in any jurisdiction to change previously established business interruption coverage terms would not only lead to protracted litigation but also larger potential losses.”

Fitch said it expects insured losses from the coronavirus outbreak to impact earnings in 2020 and 2021 but not lead to a “material deterioration” in capital for property and casualty insurers. This could change, however, as these insurers may be vulnerable to larger losses from natural disasters in the second half of 2020.