ALSTON & BIRD

Tracking Document of COVID-19 Health Care Provisions Impacting Hospitals

This chart provides an overview of health care provisions impacting hospitals in the Coronavirus Preparedness and Response Supplemental Appropriations (CPRSA) Act (1.0)[1], the Families First Coronavirus Response Act (FFCRA) (2.0)[2], the Coronavirus Aid, Relief, and Economic Security (CARES) Act (3.0)[3], and the Paycheck Protection Program and Health Care Enhancement Act (3.5)[4]. The chart includes both appropriations and authorizing provisions. Also identified below is the implementation status of each provision. Updates since the last version are in highlights.

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 ("1.0") (enacted March 6, 2020)

(New Items Highlighted)

Section	*Summary*	*Implementation*
Division A, Title III (no section identification).	$3.1 billion appropriated for the Public Health and Social Services Emergency Fund to remain available until September 30, 2024 to prevent, prepare for, and respond to coronavirus including the development of necessary countermeasures and vaccines and the purchase of vaccines, therapeutics and diagnostics, necessary medical supplies, medical surge capacity, and related administrative activity. The Secretary of Health and Human Services (HHS) may take actions to ensure that vaccines, therapeutics, diagnostics developed with this funding are affordable in the commercial market. Products purchased with these funds may be deposited in the Strategic National Stockpile. These funds may be used for grants for the construction, alteration or renovation of non-Federally owned facilities to improve preparedness and response capability at the State and local level and to produce vaccines, therapeutics and	ASPR announcement: $100 million in awards for hospitals and health systems as part of National Special Pathogens Treatment System. ASPR grant opportunity for Hospital Association COVID-19 Preparedness and Response Activities posted March 24, 2020. Application available here. Closing date April 3, 2020. HRSA announcement: $100 million awards to 1,381 health centers. Awards by state available here. HHS announced on June 2 an additional $250 million in awards to supplement the $100 million. Specific funding awards can be found here.

[1] Public Law No. 116-123. Accessed at: https://www.congress.gov/116/plaws/publ123/PLAW-116publ123.pdf.
[2] Public Law No. 116-127. Accessed at: https://www.congress.gov/116/bills/hr6201/BILLS-116hr6201enr.pdf.
[3] Public Law No. 116-136. Accessed at: https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf.
[4] Public Law No. 116-139. Accessed at: https://www.congress.gov/116/bills/hr266/BILLS-116hr266enr.pdf.

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	diagnostics where the Secretary of HHS determines that such a contract is necessary to secure sufficient amounts of supplies. $100 million are to be used for grants to community health centers (CHCs) to prevent, prepare for and respond to coronavirus. An additional $300 million is available for the purchase of products such as vaccines, therapeutics and diagnostics if the Secretary certifies to the House and Senate Appropriations Committees of the need for the additional funding to purchase amounts that are adequate to address the public health need.	
Division B, Sec. 102 Secretarial authority to temporarily waive or modify application of certain Medicare requirements with respect to telehealth services furnished during emergency periods.	The Secretary of HHS is authorized to waive certain Medicare telehealth requirements during the coronavirus public health emergency. Specifically, this section waives the "originating site" requirement so that telehealth can be used in nonrural areas and even in a patient's home. This section also allows the use of telephones for telehealth services if the telephones have audio and video capabilities that are used for two-way, real-time interactive communication. These waivers apply during the coronavirus public health emergency (declared on January 31, 2020 and effective January 27, 2020) and when the distant site practitioner (or a practitioner in his or her same practice) has a pre-existing relationship with the patient within the last three years, which is demonstrated by having provided a Medicare-reimbursed service or item to the patient.	Additional statutory changes made in subsequent laws ("2.0"and "3.0"). See below. HHS has issued the following guidance in connection with Section 1135 waivers and regulatory changes related to telehealth: CMS: General Provider Telehealth and Telemedicine Toolkit (PDF) released March 20, 2020 Fact sheet: Medicare Coverage and Payment Related to COVID-19 (PDF) updated March 23, 2020 Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet released March 17, 2020 Interim Final Rule with Comment Period: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency released March 30, 2020 Video: Provides answers to common questions about the expanded Medicare telehealth services benefit in

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		light of temporary and emergency basis under section 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. OIG: HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth Services During the COVID-19 Outbreak released March 17, 2020 Fact Sheet March 17, 2020 OCR: Notice of Enforcement Discretion for Telehealth Remote Communications released March 17, 2020 Press Release March 17, 2020 FAQs on Telehealth Remote Communications

Families First Coronavirus Response Act ("2.0") (enacted March 18, 2020)

Section	Summary	Implementation
Division A, Title IV (no section identification).	$1 billion appropriated to the Public Health and Social Services Emergency Fund for HHS to pay for claims for COVID-19 testing and related visits for uninsured individuals. Specifically, the funds will remain available until expended for activities authorized under section 2812 of the Public Health Service Act (PHSA), in coordination with the Assistant Secretary for Preparedness and Response and the Administrator of the Centers for Medicare & Medicaid Services, to pay the claims of providers for reimbursement (as described in subsection (a)(3)(D) under section	See "3.0" for more details (below) HRSA: Announced program details April 22, 2020 April 27, 2020: • Opened Provider Portal for Uninsured claims payment

Section	Summary	Implementation
	2812 of the PHSA)[5] for health services consisting of SARS-CoV-2 or COVID-19 related items, services, or visits (as described in section 6001 of this bill) for uninsured individuals. The term "uninsured individual" means an individual who is not enrolled in a federal health care program,[6] including an individual who is eligible for medical assistance (i.e., Medicaid) only because he or she was uninsured during the coronavirus outbreak, or not enrolled in a group health plan or health insurance coverage offered by a health insurance issuer in the group or individual market[7], or a health plan offered under chapter 89 of title 5, United States Code.	• Released Terms and Conditions for Testing and Treatment • Released FAQs On May 29, CDC released a new dataset that represents the list of health care entities who have agreed to the Terms and Conditions and received claims reimbursement for COVID-19 testing of uninsured individuals and/or treatment for uninsured individuals with a COVID-19 diagnosis, as of May 26, 2020. • $2.08 million has been paid for treatment. • $2.04 million has been paid for testing. As of June 2, 2020: • $10.839 million has been paid for testing • $81.963 million has been paid for treatment
Division B, Sec.6008. Temporary increase of Medicaid FMAP.	This section would increase the states' federal medical assistance percentage (FMAP) during the public health emergency period by 6.2 percent for all medical services. The increase would take place during the first day of the coronavirus emergency (defined in paragraph (1)(B) of section 1135(g) of the Social Security Act) and ending on the last day of the calendar quarter of the coronavirus emergency. A state may not receive an increase in FMAP during a quarter if:	CMS released FAQs. CMS released guidance on April 13, 2020 (see #18, 22-42)

[5] (a)(3)(D) allows the HHS Secretary to pay for health-related services for those at risk in a public emergency directly, in advance of the services, or provide reimbursement. See https://www.law.cornell.edu/uscode/text/42/300hh-11

[6] Federal health care program defined under section 1128B(f) of the Social Security Act.

[7] These terms are defined section 2791 of the PHSA.

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	• The state's eligibility standards, methodologies, or procedures are more restrictive during such quarter than the eligibility standards methodologies, or procedures, that were in effect on January 1, 2020: • The state's premium during a quarter exceeds the amount that was set as of January 1, 2020: • The state fails to provide that an individual who is enrolled as of date of enactment or an individual who enrolls during the period beginning on the date of enactment and the ending the last day of the month in which the coronavirus emergency ends shall be treated as eligible for such benefits through the end of the month in which the coronavirus emergency ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state; or • The state does not provide coverage without imposing cost sharing obligations for testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.	
Sec. 6010. Clarification relating to Secretarial authority regarding Medicare telehealth services furnished during COVID-19 emergency period	This section clarifies the telemedicine provision from the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 (1.0) to address the outbreak. The 1.0 law allows HHS to waive certain prohibitions for furnishing telehealth services during the COVID-19 outbreak. As enacted, the law requires that a qualifying provider under the waiver must have furnished services to an individual and received payment from Medicare within three years. This section clarifies that a provider would still qualify if the individual for which the provider furnished services *could* have had Medicare pay for telehealth services within three years. This is meant to cover older individuals who could have been eligible for telehealth services under Medicare, but were not on Medicare previously.	Additional statutory changes made in subsequent law ("3.0"). See A&B Telehealth Waivers and Regulatory Flexibilities Guide HHS has issued the following guidance in connection with Section 1135 waivers and regulatory changes related to telehealth: CMS: General Provider Telehealth and Telemedicine Toolkit (PDF) released March 20, 2020

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		Fact sheet: Medicare Coverage and Payment Related to COVID-19 (PDF) updated March 23, 2020 Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet released March 17, 2020 Interim Final Rule with Comment Period: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency released March 30, 2020 Video: Provides answers to common questions about the expanded Medicare telehealth services benefit in light of temporary and emergency basis under section 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Interim Final Rule with Comment Period: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program released April 30, 2020 Video: Reviews most common questions regarding telehealth visit benefits under 1135 waiver authority during the COVID-19 public health emergency OIG: HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth

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		Services During the COVID-19 Outbreak released March 17, 2020 Fact Sheet March 17, 2020 OCR: Notice of Enforcement Discretion for Telehealth Remote Communications released March 17, 2020 Press Release March 17, 2020 FAQs on Telehealth Remote Communications

CARES Act – Health Provisions ("3.0") (enacted March 27, 2020)

Section	Summary	Implementation
Division B, Title VIII (no section identification)	$100 billion for the Public Health and Social Services Emergency fund "to prevent, prepare for and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for the health care related expenses or lost revenues that are attributable to coronavirus." Eligible health care providers are defined as "public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit and not-for-profit entities not otherwise described as the Secretary may specify, within the United States (including territories) that provide diagnosis, testing or care for individuals with possible or actual cases of COVID-19." Funds will be available for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities and surge capacity. These	CMS: Announced on April 7, 2020 that $30 billion would be provided to health care providers based on Medicare billing history. CMS also stated that non-Medicare billing providers would receive distributions in a subsequent wave of grants. HHS: Announced on April 10, 2020 that funds are being distributed. Portal to attest to Terms and Conditions released April 16, 2020 Updated Terms and Conditions available here, which specify that balance billing is prohibited for all care for a presumptive or actual case of COVID-19

Section	Summary	Implementation
	funds may not be used to reimburse expenses and losses that other sources are obligated to reimburse. In order to be eligible for a payment, a health care provider is required to submit an application that includes a statement justifying the need for the payment and the also must have a valid tax identification number. The Secretary of HHS is required to review applications and make payments on a rolling basis, which can be in the form of a grant or other mechanism and can provided on a pre-payment, prospective payment or retrospective payment basis.	Announced additional details on disbursements on April 22, 2020. Specifically: an additional $20 billion to augment the first $30 billion; $10 billion for COVID-19 "High Impact" areas; $10 billion for rural providers; and additional allocations for the uninsured and other providers (potentially SNFs, dentists, Medicaid-only providers) Announced on April 23, 2020 that the deadline for submitting information for the COVID-19 "High Impact" areas was extended to 3pm ET on April 25, 2020 Released a state-by-state breakdown of the initial $30 billion distribution Released FAQs on General Distribution Portal Revised General Distribution FAQs on May 7 Revised Provider Relief Fund FAQs on May 15 Revised Provider Relief Fund FAQs on May 19 Revised Provider Relief Fund FAQs on May 20 Revised Provider Relief Fund FAQs on May 21 Revised Provider Relief Fund FAQs on May 29 Revised Provider Relief Fund FAQs on June 2 Revised Provider Relief Fund FAQs on June 3 Revised Provider Relief Fund FAQs on June 8 Revised Provider Relief Fund FAQs on June 9 Revised Provider Relief Fund FAQs on June 10 Revised Provider Relief Fund FAQs on June 15 Revised Provider Relief Fund FAQs on June 16 Announced on April 28, 2020 that it "has received data from hospitals [for the High Impact Areas distribution] throughout the country and is preparing to release funds to hospitals. More information is coming soon."

Section	Summary	Implementation
		Released a congressional district breakdown of the initial $30 billion distribution Announced distribution of High Impact and Rural Area PRF distributions on May 1, 2020. Note that the High Impact distribution has been increased from $10 billion to $12 billion to account for Medicare and Medicaid disproportionate share and uncompensated care payments Released data on providers who received and attested to payment from the General Distribution on May 6 Announced extension of deadline from 30 to 45 days to confirm receipt and attest to Terms and Conditions on May 7 Announced a deadline of June 3 to submit revenue information to support receiving additional payment from the $50 billion General Distribution Released Terms and Conditions for High Impact and Rural Provider distributions Released allocation methodology for High Impact and Rural Provider distributions on May 8 Announced nearly $4.9 billion distribution to nursing facilities, and released state-by-state breakdown on May 22 Announced $500 million distribution to IHS on May 22 Announced extension of attestation deadline to 90 days after receipt of payment on May 22 Released the IHS Targeted Allocation Terms and Conditions on June 1 Announced new Provider Relief Fund Targeted Distributions to Medicaid-only providers, Safety Net

Section	Summary	Implementation
		Hospitals, and an additional High Impact distribution on June 9 Released Safety Net Hospital Terms and Conditions and state-by-state breakdown, and Medicaid-Only Terms and Conditions on June 9 Released the Medicaid-Only portal, instructions, and the application form on June 10 Released additional information on the Safety Net Hospital Distribution on June 11 Provided additional details on the Safety Net Hospital Distribution methodology Announced two webinars on the Medicaid Distribution application process, one on June 23 at 2PM ET and one on June 25 at 2PM ET Released a CARES Act PRF Distribution Summary HRSA: April 27, 2020: • Opened Provider Portal for Uninsured claims payment • Released Terms and Conditions for Testing and Treatment • Released FAQs April 29-30, 2020 • Held webinars on the Uninsured Program • Released FAQs following webinars on May 7 On May 29, CDC released the following: 1. A new dataset that represents the list of health care entities who have agreed to the Terms and

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		Conditions and received claims reimbursement for COVID-19 testing of uninsured individuals and/or treatment for uninsured individuals with a COVID-19 diagnosis, as of May 26, 2020. • $2.08 million has been paid for treatment. • $2.04 million has been paid for testing. 2. An updated dataset that represents the list of providers that received a payment from the General Distribution, High Impact Targeted Allocation and/or the Rural Targeted Allocation of the Provider Relief Fund, and who have attested to receiving one or more payments and agreed to the Terms and Conditions as of May 29, 2020. • $45.874 billion of the $72 billion allocated to these distribution pools has been attested to. As of June 2, 2020: • $10.839 million has been paid for testing • $81.963 million has been paid for treatment As of June 3, 2020: • $49.875 billion of the $72 billion allocated to the General, High Impact, and Rural distribution pools has been attested to As of June 8, 2020: • $52.611 billion of the $76.873 billion allocated to the General, High Impact (round 1), Rural, and SNF distribution pools has been attested to As of June 10, 2020:

Section	*Summary*	*Implementation*
		• $52.983 billion of the $76.873 billion allocated to the General, High Impact (round 1), Rural, and SNF distribution pools has been attested to As of June 12, 2020: • $23.605 million has been paid for testing • $130.030 million has been paid for treatment
Division B, Title VIII (no section identification)	$250 million Grants/cooperative agreements with grantees or sub-grantees of the Hospital Preparedness Program.	
Division B, Title VIII (no section identification)	$275 million to expand service and capacity for rural hospitals, telehealth, poison control centers, and the Ryan White HIV/AIDS program. Also provides community health centers (CHCs) with flexibility on how to use FY 2020 funding.	Announced awards of $150 million to 1,779 small and rural hospitals and $11.5 million to the 14 HRSA-funded Telehealth Resource Centers on April 22, 2020 Announced nearly $5 million in awards to poison control centers on April 23, 2020 Announced $20 million in awards through HRSA's Maternal and Child Health Bureau and Federal Office of Rural Health Policy on April 30, 2020 Announced $15 million in awards through HRSA's Bureau of Health Workforce on May 13, 2020
Division B, Title VIII (no section identification)	$200 million to the Federal Communications Commission to remain available until expended to prevent, prepare for, and to respond to coronavirus, including to support efforts of health care providers to address coronavirus by providing telecommunications services, information services and devices necessary to provide telehealth services during the emergency period.	COVID-19 Telehealth Program announced on March 30, 2020. Press Release March 30, 2020 Report and Order released April 2, 2020 Guidance on COVID-19 Telehealth Program Application Process released April 8, 2020 Announced April 10, 2020 that the COVID-19 Telehealth Program Application Form released Announced on April 16, 2020 that six health care providers were awarded funding

Section	*Summary*	*Implementation*
		Guidance on invoicing the FCC for COVID-19 Telehealth Program-funding services and/or connected devices released April 17, 2020 Announced on April 21, 2020 that it is waiving the "red light" rule for the COVID-19 Telehealth Program Announced on April 21, 2020 that five additional health care providers were awarded funding Announced on April 23, 2020 that six additional health care providers were awarded funding Announced on April 29, 2020 that 13 additional health care providers were awarded funding Announced on May 6, 2020 that 26 additional health care providers were awarded funding Announced on May 13, 2020 that 33 additional health care providers were awarded funding Announced on May 20, 2020 that 43 additional health care providers were awarded funding Announced on May 28, 2020 that 53 additional health care providers were awarded funding Announced on June 3, 2020 that 53 additional health care providers were awarded funding Announced on June 10, 2020 that 67 additional health care providers were awarded funding Announced on June 17, 2020 that 62 additional health care providers were awarded funding
Division A, Title I. Keeping American workers paid and employed act.	Among other things, this title establishes the Paycheck Protection Program (PPP) through the Small Business Administration (SBA). The PPP provides new loan options for eligible recipients, which can be forgiven. In addition, this title provides certain emergency grants through the SBA's Economic Injury Disaster Loan (EIDL) program.	SBA Interim Final Rule released April 24, 2020 that clarifies that hospitals otherwise eligible to receive a PPP loan as a business concern or a nonprofit organization will be eligible even if it is owned by a state or local government and receives less than 50% of its funding

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	Overall, this title provides $349 billion for PPP loans and $10 billion for the EIDL emergency grants.	form state or local government sources (exclusive of Medicaid). SBA PPP FAQs (continually updated) available here SBA PPP Loan Forgiveness Application available here SBA PPP Loan Forgiveness Interim Final Rule
Division A, Sec. 3211. Supplemental awards for health centers.	$1.32 billion in supplemental funding to community health centers for testing and treating COVID-19 patients.	Press Release April 8, 2020 List of Recipients
Division A, Sec. 3212. Telehealth network and telehealth resource centers grant programs.	This section modernizes the telehealth network grant program and telehealth resource centers grant program. The telehealth network grant program's changes reflect a shift from demonstration of telehealth technology to delivery of telehealth services. The telehealth resource centers grant program shifts from demonstration to telehealth initiative support services. Both grant programs are extended from four-year periods to five-year periods. Both grant programs remove the requirement that the recipient be a nonprofit entity, permitting for-profit entities to participate. The percentage of funds that may be utilized for purchase or lease of equipment is reduced from 40 to 20 percent of the award. Within four years after enactment, the Secretary of HHS must report on activities and outcomes of these grant programs to the Senate Health, Education, Labor, and Pensions (HELP) Committee and the House Energy and Commerce (E&C) Committee. Such report must be issued every five years. This section authorizes $29 million for each of fiscal years 2021 through 2025 for such grants.	Announced awards of $150 million to 1,779 small and rural hospitals and $11.5 million to the 14 HRSA-funded Telehealth Resource Centers on April 22, 2020
Division A, Sec. 3213. Rural health care services outreach, rural health network development, and	This section modifies the rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs.	

Section	*Summary*	*Implementation*
small health care provider quality improvement grant programs.	The grant period for each program is extended from three to five years. The section also provides $79.5 million of funding for each of fiscal years 2021 through 2025. The rural health care services outreach and rural health network development grant programs are modified to permit for-profit entities to participate. The small health care provider quality improvement grant program is modified to permit regional, not just local, providers to participate, and to apply to efforts to increase care coordination and chronic disease management. Within four years after enactment, the Secretary of HHS must report on activities and outcomes of these grant programs to the Senate HELP Committee and the House E&C Committee. Such report must be issued every five years.	
Division A, Sec. 4003. Emergency relief and taxpayer protections.	This section provides $500 billion to the Department of Treasury's Exchange Stabilization Fund to provide loans, loan guarantees, and other investments. $454 billion (as well as any amounts not used for direct lending for passenger air carriers, cargo air carriers, and "businesses important to maintaining national security") is provided to support the Federal Reserve's lending facilities to eligible businesses, states, and municipalities. The lending must meet the following criteria: (1) alternative financing is not reasonably available to the business; (2) the loan is sufficiently secured or made at an interest rate that reflects the risk of the loan (and, if possible, not less than an interest rate based on market conditions for comparable obligations before the COVID-19 outbreak); (3) the duration of the loan will be as short as possible, not to exceed 5 years; (4) borrowers and affiliates must agree not to engage in stock buybacks (unless previously contractually obligated) or pay dividends until one year after the date of repayment of the loan;	Federal Reserve: Announced on April 9, 2020 actions to provide up to $2.3 trillion in loans. As part of this the Federal Reserve released the following term sheets: • Term Asset-Backed Securities Loan Facility • Primary Market Corporate Credit Facility • Secondary Market Corporate Credit Facility • Municipal Liquidity Facility • Paycheck Protection Program Lending Facility • Main Street New Loan Facility • Main Street Expanded Loan Facility Also see the A&B Advisory on the Main Street Lending Program. On May 12, 2020:

Section	*Summary*	*Implementation*
	(5) borrowers must commit to maintain employment levels as of March 24, 2020 until September 30, 2020 to the extent practicable, and must retain no less than 90 percent of their employees as of March 24, 2020; (6) a borrower must certify that it is a US-domiciled business and its employees are predominantly located in the US; (7) the loan cannot be forgiven; and (8) for borrowers critical to national security, their operations must be jeopardized by losses related to the COVID-19 pandemic.	Announced Start of Secondary Market Corporate Credit Facility Purchases Updates to Term Sheet for Municipal Liquidity Facility Updates to TALF term sheet
SUBPART C—MISCELLANEOUS PROVISIONS		
Sec. 3221. Confidentiality and disclosure of records relating to substance use disorder.	This section modifies the 42 CFR Part 2 regulations governing privacy protections of substance use disorder records (often referred to as "Part 2 records") to align with those of Health Insurance Portability and Accountability Act (HIPAA) if the patient consents in writing. Once prior written consent of the patient has been obtained, the contents of the record may be used or disclosed by a covered entity, business associate, or other programs subject to the confidentiality requirements of 42 USC § 290dd-2 for purposes of treatment, payment, and health care operations as permitted by HIPAA regulations. Such records may be redisclosed in accordance with HIPAA regulations. The patient's prior written consent may be given once for all such future uses or disclosures for treatment, payment, and operations, until the consent is revoked in writing. This section also permits de-identified substance use disorder record information to be disclosed to a public health authority without patient consent. This section also clarifies that the penalties for breaches and wrongful disclosure of individually identifiable health information apply to substance use disorder records. This section prohibits discrimination against an individual on the basis of information received through inadvertent or intentional disclosure of information in substance use disorder records in the context of health care, employment, housing, legal processes, or government benefits. The Secretary of HHS must make conforming revisions to regulations. Regulations regarding	

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	the requirement for notice of privacy practices must be revised to require inclusion of a statement of the substance use disorder patient's rights, as well as self-pay patients, with respect to protected health information and a brief description of how the individual may exercise these rights, and a description of each purpose for which the covered entity is permitted or required to use or disclose protected health information without the patient's written authorization. This section also prohibits the use of records against the patient in criminal, civil, or administrative, or legislative proceedings conducted by any Federal, State, or local authority, except as authorized by a court order or by the consent of the patient. The implementing regulations must be effective one year after the date of enactment.	
Sec. 3224. Guidance on protected health information.	This section requires the Secretary of HHS to issue guidance on the sharing of patients' protected health information under HIPAA regulations during the Section 319 public health emergency declaration, the Stafford Act emergency declaration, and the national emergency under the National Emergencies Act with respect to COVID-19. Guidance must be issued no later than 180 days after enactment.	
Sec. 3703. Increasing Medicare telehealth flexibilities during emergency period.	This section permits the Secretary of HHS to waive under section 1135 of the Social Security Act any requirement of section 1834(m) of the Social Security Act (SSA) relating to telehealth services during the COVID-19 public health emergency.	See A&B Telehealth Waivers and Regulatory Flexibilities Guide HHS has issued the following guidance in connection with Section 1135 waivers and regulatory changes related to telehealth: CMS:

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		General Provider Telehealth and Telemedicine Toolkit (PDF) released March 20, 2020 Fact sheet: Medicare Coverage and Payment Related to COVID-19 (PDF) updated March 23, 2020 Fact sheet: Medicare Telemedicine Healthcare Provider Fact Sheet released March 17, 2020 Interim Final Rule with Comment Period: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency released March 30, 2020 Video: Provides answers to common questions about the expanded Medicare telehealth services benefit in light of temporary and emergency basis under section 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Interim Final Rule with Comment Period: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program released April 30, 2020 Video: Reviews most common questions regarding telehealth visit benefits under 1135 waiver authority during the COVID-19 public health emergency OIG:

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		HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth Services During the COVID-19 Outbreak released March 17, 2020 Fact Sheet March 17, 2020 OCR: Notice of Enforcement Discretion for Telehealth Remote Communications released March 17, 2020 Press Release March 17, 2020 FAQs on Telehealth Remote Communications
Sec. 3709. Adjustment of sequestration.	This section exempts Medicare programs from reduction under any sequestration order issued before, on, or after enactment. This exemption applies during the period of May 1, through December 31, 2020. In addition, this section extends the sequestration required in Section 251A(6) of the Balanced Budget and Emergency Deficit Control Act (BBEDCA) of 1985 from fiscal year 2029 to fiscal year 2030.	CMS guidance implementing the temporary suspension of Medicare sequestration released April 10, 2020
Sec. 3710. Medicare hospital inpatient prospective payment system add-on payment for COVID–19 patients during emergency period.	For discharges occurring during the COVID-19 emergency period for COVID-19 diagnoses, the Secretary of HHS must increase the weighting factor by 20 percent for such diagnoses. This effectively increases Medicare payment to hospitals for treating Medicare beneficiaries for COVID-19. The Secretary must identify a discharge of the patient through diagnosis codes, condition codes, or "other such means as may be necessary." According to summaries from congressional committees, this is an effort to "expedite the use of a COVID-19 diagnosis" and develop appropriate payments to hospitals for treating COVID-19 patients. This payment adjustment does not consider budget neutrality requirements.	New diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

Section	*Summary*	*Implementation*
	If a state has waived all or part of this section under 1115A waiver authority, then the state may develop its own payment adjustment. The Secretary may implement this section by program instruction or otherwise.	
Sec. 3711. Increasing access to post-acute care during emergency period.	This section will give hospitals flexibility to transfer patients out of their facilities and into inpatient rehabilitation facility (IRFs) and long-term care hospitals (LTCHs). It waives the three-hour IRF rule, which requires the patient to receive three hours of therapy per day over a five-day period or 15 hours over a week, during the COVID-19 emergency period. This section also waives the site neutral payment rate provisions in LTCHs during the emergency period. Specifically, it waives: • the 50 percent rule that relates to the payment adjustment for LTCHs that do not have a discharge payment percentage for the period that is at least 50 percent; and • the site neutral Inpatient Prospective Payment System rate (described at 42 USC § 1395ww(m)(6)(A)(i)).	
Sec. 3715. Providing home and community-based services in acute care hospitals.	This section adds language to the Medicaid statute (section 1902(h) of the SSA) to allow personal assistance services and home and community-based attendant services to be provided and reimbursed by state Medicaid programs during a beneficiary's acute care hospital stay. This is intended reduce hospital lengths of stay.	
3719. Expansion of the Medicare Hospital Accelerated Payment Program During the	This section amends a program that allows the Secretary of HHS to provide payments to hospitals that have significant cashflow problems resulting from unusual circumstances (see Sec. 1815(e)(3) of the SSA).	Program rolled out on March 28, 2020 CMS Press release CMS Fact Sheet updated April 26, 2020 stating that CMS will not be accepting any new applications for the

Section	*Summary*	*Implementation*
COVID-19 Public Health Emergency.	Specifically, during the emergency period, this section expands the above-mentioned program to children's hospitals, cancer hospitals and critical access hospitals (CAHs). Subject to fraud, waste, and abuse safeguards, the Secretary may make accelerated payments upon request from the hospitals. The Secretary may make the payments on a periodic or lump sum basis. The payments may be based on 100 percent (or 125 percent for CAHs) of prior payments. The period for the payments may be up to six months. Qualifying hospitals would not be required to pay back HHS for 120 days and would have 12 months to complete the payment. The Secretary may implement this section through program instruction or otherwise.	"Advance Payment Program" (for Part B providers and suppliers) and will be reevaluating all pending and new applications for the "Accelerated Payment Program" (for Part A providers) (also see April 26, 2020 press release) CMS Update – $34 billion distributed in the last week (per press release on April 7, 2020) CMS Update – $51 billion distributed (per news alert on April 9, 2020) CMS Update - $63.4 billion distributed as of April 10 CMS Update - $94.7 billion distributed as of April 17 CMS Update - $100.1 billion distributed as of April 24 CMS Update – $100.3 billion distributed as of May 2, including a breakdown by state and provider type, released on May 10 State Provider details released on May 10 (auto-download of zip file available here) HHS applied a 9.625% interest rate for the 3rd quarter of fiscal year 2020 (April-June) on overdue and delinquent debts
3720. Special Rules Related to Temporary Increase Medicaid FMAP.	This section adds exceptions to the requirements for the increased Federal medical assistance percentage (FMAP), which was authorized by the FFCRA. Among other provisions, the FFCRA prohibited a state from receiving the 6.2 percent increase in FMAP if the state restricted eligibility or raised premiums (see Sec. 6008(b)(1)-(4) of the FFCRA) during the emergency period. This section would allow a state to receive the increase, regardless of the requirements if 60 days after enactment the state certifies it is unable to meet the requirements and the state does not enact stricter eligibility standards or higher premiums than what were in place on the date of enactment.	CMS released guidance on April 13, 2020 (see #23)

Section	Summary	Implementation
	The section also clarifies that federal financial participation would be available for medical assistance furnished to individuals whom the state is required to treat as eligible.	
Sec. 3813. Delay of DSH reductions.	This section delays the Medicaid Disproportionate Share Hospital (DSH) allotment reductions from May 23, 2020 through September 30, 2020 to December 1, 2020 through September 30, 2021.	CMS released guidance on April 13, 2020 (see #43)

Paycheck Protection Program and Health Care Enhancement Act ("3.5") (enacted April 24, 2020)

Section	Summary	Implementation
Division A, Small business programs.	This division adds $310 billion to the PPP and adds $10 billion to the emergency EIDL grants.	SBA Interim Final Rule released April 24, 2020 that clarifies that hospitals otherwise eligible to receive a PPP loan as a business concern or a nonprofit organization will be eligible even if it is owned by a state or local government and receives less than 50% of its funding form state or local government sources (exclusive of Medicaid). SBA PPP FAQs (continually updated) available here
Division B, Title I (no section identification).	$75 billion for the Provider Relief Fund as established in the CARES Act.	See "3.0" for more details (above)
Division B, Title I (no section identification).	$11 billion for COVID-19 testing to States, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes. These funds must be allocated within 30 days of enactment. • $2 billion based on Public Health Emergency Preparedness (PHEP) cooperative agreement in FY 2019 • $4.25 billion based on relative number of COVID-19 cases • $750 million in coordination with the Indian Health Service	HHS announced $10.25 billion to states, territories, and local jurisdictions through CDC's existing Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement. IHS will provide $750 million to IHS, tribal, and urban Indian Health programs to expand testing capacity and testing-related activities. The list of funding recipients is available here

Section	*Summary*	*Implementation*
	Funds must be allocated by May 22. In addition, up to $1 billion may be used to cover testing for the uninsured.	
Division B, Title I (no section identification).	$1 billion for CDC-wide Activities and Program Support (surveillance, epidemiology, laboratory capacity expansion, contact tracing, public health data surveillance and analytics infrastructure modernization, disseminating information about testing, and workforce support) necessary to expand and improve COVID-19 testing.	
Division B, Title I (no section identification).	$600 million for grants under the PHSA Section 330 Health Centers program and for grants to FQHCs.	HHS announced nearly $583 million in awards to 1,385 HRSA-funded health centers on May 7
Division B, Title I (no section identification).	$225 million to rural health clinics for COVID-19 testing and related expenses. Funds will be distributed using the procedures developed for the Provider Relief Fund authorized by the CARES Act, may be distributed using contracts or agreements established for such program, and will be subject to the process requirements applicable to the Provider Relief Fund.	HHS announced $225 million in awards to 4,549 rural health clinics for COVID-19 testing in rural communities on May 20