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], and the Coronavirus Aid, Relief, and Economic Security (CARES) Act (3.0)[3]. 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)

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.

[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] S. 3548, enacted as amendment in nature of a substitute to H.R. 748.

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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 OIG:

Section	Summary	Implementation
		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 Act 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 2812 of the PHSA)[4] 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.	

[4] (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

Section	Summary	Implementation
	The term "uninsured individual" means an individual who is not enrolled in a federal health care program,[5] 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[6], or a health plan offered under chapter 89 of title 5, United States Code.	
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: • 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	CMS released FAQs.

[5] Federal health care program defined under section 1128B(f) of the Social Security Act.
[6] These terms are defined section 2791 of the PHSA.

Section	Summary	Implementation
	• 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"). 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 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

Section	Summary	Implementation
		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)

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 funds may not be used to reimburse expenses and losses that other sources are obligated to reimburse.	

Section	*Summary*	*Implementation*
	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.	
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.	
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
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	

Section	Summary	Implementation
	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.	
Sec. 3213. Rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs.	This section modifies the rural health care services outreach, rural health network development, and 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.	
SUBPART C—MISCELLANEOUS PROVISIONS		
Sec. 3221. Confidentiality and disclosure of records	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	

Section	*Summary*	*Implementation*
relating to substance use disorder.	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 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.	

Section	*Summary*	*Implementation*
	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.	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 OIG: HHS OIG Policy Statement on Practitioners That Reduce, Waive Amounts Owed by Beneficiaries for Telehealth

Section	*Summary*	*Implementation*
		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.	
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.	A 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

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.	
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. 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.	