TO: Health Care Clients
FROM: Alston & Bird LLP
DATE: March 16, 2020
RE: A&B Summary— Health Provisions of H.R. 6201, the Families First Coronavirus Response Act

On March 14, 2020, the House of Representatives passed a second bill related to addressing the Coronavirus Disease 2019 (also referred to as COVID-19 herein) outbreak by a 363-40 (and one present) vote. H.R. 6201, the Families First Coronavirus Response Act\(^1\) provides additional funding as well as several policy changes to address the outbreak. On March 16, 2020, the House passed H. Res. 904\(^2\), which made technical corrections to H.R 6201.

Below is a summary of the health-related provisions in the bill, as amended by H. Res. 904. Please note that changes to the health-related provisions include:

- **Section 6001. Coverage of Testing for COVID-19**
  - Clarification that health care provider office visits during which COVID-19 testing takes place include in-person visits and telehealth visits

- **Section 6002. Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19**
  - Adds online digital evaluation and management services as COVID-19 testing-related services

- **Section 6008. Temporary Increase of Medicaid FMAP**
  - Makes changes to criteria for receiving a Federal Medicaid Assistance Percentage (FMAP)

**Division A – Second Coronavirus Preparedness Response Supplemental Appropriations Act, 2020**

*Title IV – Department of Health and Human Services: Indian Health Service*

$64 million would be provided to the Indian Health Service (IHS) through September 30, 2022 for health services or items, described below in section 6007, related to COVID-19. These amounts would be allocated at the discretion of the Director of the Indian Health Service. Additionally, these funds are designated by Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

*Title V – Department of Health and Human Services: Administration for Community Living*

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1. See [https://docs.house.gov/billsthisweek/20200309/BILLS-116hr6201-SUS.pdf](https://docs.house.gov/billsthisweek/20200309/BILLS-116hr6201-SUS.pdf)
The bill provides for $250,000,000 for Aging and Disability Services Programs through September 30, 2021 for nutrition service grant programs and Native American nutrition services. Out of this funding, $160,000,000 would be for home-delivered nutrition services, $80,000,000 would be for congregate nutrition services, and $10,000 would be for Native American nutrition services. State matching requirements under the Older Americans Act (sections 304(b)(1)(D) and 309(b)(2)) do not apply to these funds. These funds are also designated by Congress as being an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

Title V – Office of the Secretary: Public Health and Social Services Emergency Fund

The bill provides $1,000,000,000 for HHS to pay for claims for services related to COVID-19 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 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) 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, including an individual who is eligible for medical assistance (i.e., Medicaid) only because they are 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, or a health plan offered under chapter 89 of title 5, United States Code.

This funding is designated by Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

Title VI – Department of Veterans Affairs: Veterans Health Administration

The bill provides $30,000,000 to the Veterans Health Administration through September 30, 2022 for health services consisting of SARS-CoV-2 or COVID-19 related items and services as described in section 6006 below (or for the administration of such products). A further $30,000,000 for Medical Community Care is also available for the same time period, services, and items.

These funds are designated by Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

Title VII – General Provisions – This Act

The head of each executive agency receiving funding must submit a report detailing the anticipated uses of all such funding to the House and Senate Committees on Appropriations within 30 days. Each report must include estimated costs for personnel and administrative activities, as well as the total amount of funding apportioned, allotted, obligated, and expended. The agencies must then report every 60 days until the

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3 (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
4 Federal health care program defined under section 1128B(f) of the Social Security Act.
5 These terms are defined section 2791 of the PHSA.
funding expires or is expended. States and local governments receiving funding must ensure the respective State Emergency Operations Centers are providing regular and real-time reporting on aggregated data on testing and results from public health departments to the Centers for Disease Control and Prevention (CDC).

**Division F- Health Provisions**

*Sec. 6001. Coverage of Testing for COVID-19*

This provision would require a group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) to provide coverage, and apply no cost sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements, for specific items and services during the coronavirus public health emergency declared by the Department of Health and Human Services (HHS) Secretary pursuant to section 319 of the PHSA (referred to as the “coronavirus emergency” herein).

The following services must be covered:

- In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by the Food and Drug Administration (FDA), and the administration of such in vitro diagnostic products;
- Items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product (described immediately above), but only to the extent the items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

HHS, Department of Labor, and Department of Treasury would apply this section to group health plans and health insurance issuers offering group or individual health insurance coverage through the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (IRC) and would be able to implement the provisions through “sub-regulatory guidance, program instruction or otherwise.”

*Sec. 6002. Waiving Cost Sharing Under the Medicare Program for Certain Visits Relating to Testing for COVID-19*

This section would require Medicare to impose no cost-sharing obligations (i.e., no co-payment or deductible) under Medicare Part B for visits related to testing or COVID-19 that take place during the coronavirus emergency. The amounts for COVID-19 testing-related services would be paid at 100 percent of the payment amount otherwise recognized under the respective specified outpatient payment provision.

The bill describes a COVID-19 testing-related service as a medical visit that:

- Is in any of the following categories of HCPCS evaluation and management service codes:
  - Office and other outpatient services;

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6 Defined in section 1251(e) of the Patient Protection and Affordable Care Act


8 FDA authorizations must be under sections 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act.
Hospital observation services;
Emergency department services;
Nursing facility services;
Domiciliary, rest home, or custodial care services;
Home services; and
Online digital evaluation and management services.

- Is furnished during any portion of the coronavirus emergency (beginning on or after date of enactment);
- Results in an order for or administration of a clinical diagnostic laboratory test; and
- Relates to the furnishing or administration of such test or to the evaluation of such individual for purposes of determining the need for such test.

HHS would be required to provide a claims modifier to identify COVID-19 testing-related services for which payment may be made under the following outpatient payment provisions:
- Hospital outpatient prospective payment system (PPS);
- Physician fee schedule;
- PPS for federally qualified health centers;
- Outpatient critical access hospital services; and
- Rural health clinic services.

The HHS Secretary may implement these provisions through program instruction.


Medicare Advantage (MA) plans would not be able to impose cost sharing obligations for clinical diagnostic laboratory tests administered during the coronavirus emergency (beginning on or after enactment) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such test as well as the visit to receive the testing. MA plans also may not impose any prior authorization or other utilization management requirements for COVID-19 testing or other utilization management requirements that are administered or furnished during any part of the coronavirus emergency.

The HHS Secretary would able to implement this section though program instruction.

Sec. 6004. Coverage at No Cost Sharing of COVID-19 Testing Under Medicaid and CHIP

This section would provide coverage for in vitro diagnostic products administered during any portion of the coronavirus emergency (beginning on or after enactment) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized by the FDA and the administration of such products. This section also would require no cost sharing obligations for individuals on Medicaid or the Children’s Health Insurance Program (CHIP) for testing COVID-19 and the visit for which testing was administered during the coronavirus emergency (beginning on or after enactment). This also provides a clarification that the section would apply to U.S. territories.

10 FDA authorizations must be under sections 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act.
Additionally, this section would provide states an option to provide coverage for uninsured individuals for COVID-19 services and visits during the emergency period (beginning on or after enactment). An uninsured individual is defined as not enrolled in Medicaid or in a federal health care program, a group health plan or individual health insurance coverage offered by a health insurance issuer (as such terms are defined in section 2791 of the PHSA), or a health plan offered under chapter 89 of title 5, United States Code.

The federal government would provide a 100 percent match for the services and items rendered under the state option. The government could also pay for administrative costs if the state can demonstrate the administrative costs were related to providing medical assistance to the uninsured.

This section also would apply to state CHIP programs, which would have to cover in vitro diagnostic testing during the coronavirus emergency (beginning on or after enactment) and apply no cost sharing requirements. This section also would provide an option to cover targeted low-income pregnant women through a state plan amendment.

**Sec. 6005. Treatment of Personal Respiratory Protective Devices as Covered Counter Measures**

This section would include certain respiratory protective respiratory masks in the definition of “covered countermeasure” for purposes of the Public Readiness and Emergency Preparedness (PREP) Act. The PREP Act provides manufacturers immunity from liability for claims arising out of the manufacture of covered countermeasures when the HHS Secretary issues a declaration under the law. Specifically, this provision would apply to a personal respiratory protective device that is: (1) Approved by the National Institute for Occupational Safety and Health; (2) Subject to subject to the March 2, 2020 emergency use authorization, which authorized emergency use of personal respiratory protective devices during the COVID-19 outbreak; and (3) Used during the period beginning on January 27, 2020, and ending on October 1, 2024 in response to the public health emergency declared on January 31, 2020.

**Sec. 6006. Application with Respect to Tricare, Coverage for Veterans, and Coverage for Federal Civilians**

The Secretary of Defense would be prohibited from requiring copayments or other cost sharing for in vitro diagnostic products or visits as described in section 6001 of this bill for the duration of the coronavirus emergency. The Secretary of Veterans Affairs may not require any copayment or other cost sharing for the same services and period of time. Those in civil service (e.g., all appointed positions in the judicial, executive, and legislative branches) enrolled in a health benefits plan, may not have copayments or other cost sharing requirements for the same services described in section 6001.

**Sec. 6007. Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care**

The HHS Secretary would be required to cover, without cost sharing requirements, the costs of providing any COVID-19 related items and services or visits to receive these items and services for individuals receiving services through IHS, including an Urban Indian Organization, regardless of whether the services

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12 The bill uses the statutory definition of civil service at Section 2101(1) of title 5, United States Code.
have been authorized under the purchased/referred care system funded by the IHS or is covered by the IHS.
This applies to services furnished during the coronavirus emergency.

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
- 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. 6009. Increase in Medicaid Allotments for Territories

This section would increase Medicaid allotments for the U.S. territories for 2020 and 2021.

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 (Coronavirus I) to address the outbreak. The Coronavirus I 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 the individual was not on Medicare previously. The Centers for Medicare & Medicaid Services has yet to promulgate guidance on this waiver authority.  

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We hope this summary was helpful to you. Please do not hesitate to contact us if you have any questions.
